DOCUMENT RESUME

ED 321 212 CG 022 661

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TITLE What Legislators Need To Know about Children's Mental Health.
INSTITUTION National Conference of State Legislatures, Denver, CO.
SPONS AGENCY Robert Wood Johnson Foundation, New Brunswick, N.J.
REPORT NO ISBN-55516-688-1
PUB DATE Apr 90
NOTE 57p.
PUB TYPE Reports - General (140) -- Guides - General (050)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS *Children; Delivery Systems; *Emotional Disturbances; *Financial Support; Government Role; *Mental Health Programs; Social Services; State Legislation; State Programs

ABSTRACT

This booklet attempts to provide important background information on programming and financing systems for children with emotional disturbances to enable legislators to make educated decisions regarding child mental health in their states. The booklet is in a question-and-answer format. The first two questions define emotional disturbance and present factors of concern to legislators, including increased services demand; inappropriate and inadequate services; and fragmented, uncoordinated delivery and funding mechanisms. Question Three outlines the services needed by children with emotional disturbances in the areas of mental health, social services, education, health care, vocational assistance, recreation, and family support. Question Four examines how services are delivered to children with emotional disturbances through the educational, juvenile justice, health, child welfare, and mental health systems. Question Five reviews the roles of federal, state, local, and private funding sources for serving children with emotional disturbances. Question Six examines strategies to make the most efficient use of available resources at the federal, state, and local levels. Question Seven highlights innovative programs that a variety of states have implemented to improve the programming and financing of services for children with emotional disturbances. (ABL)

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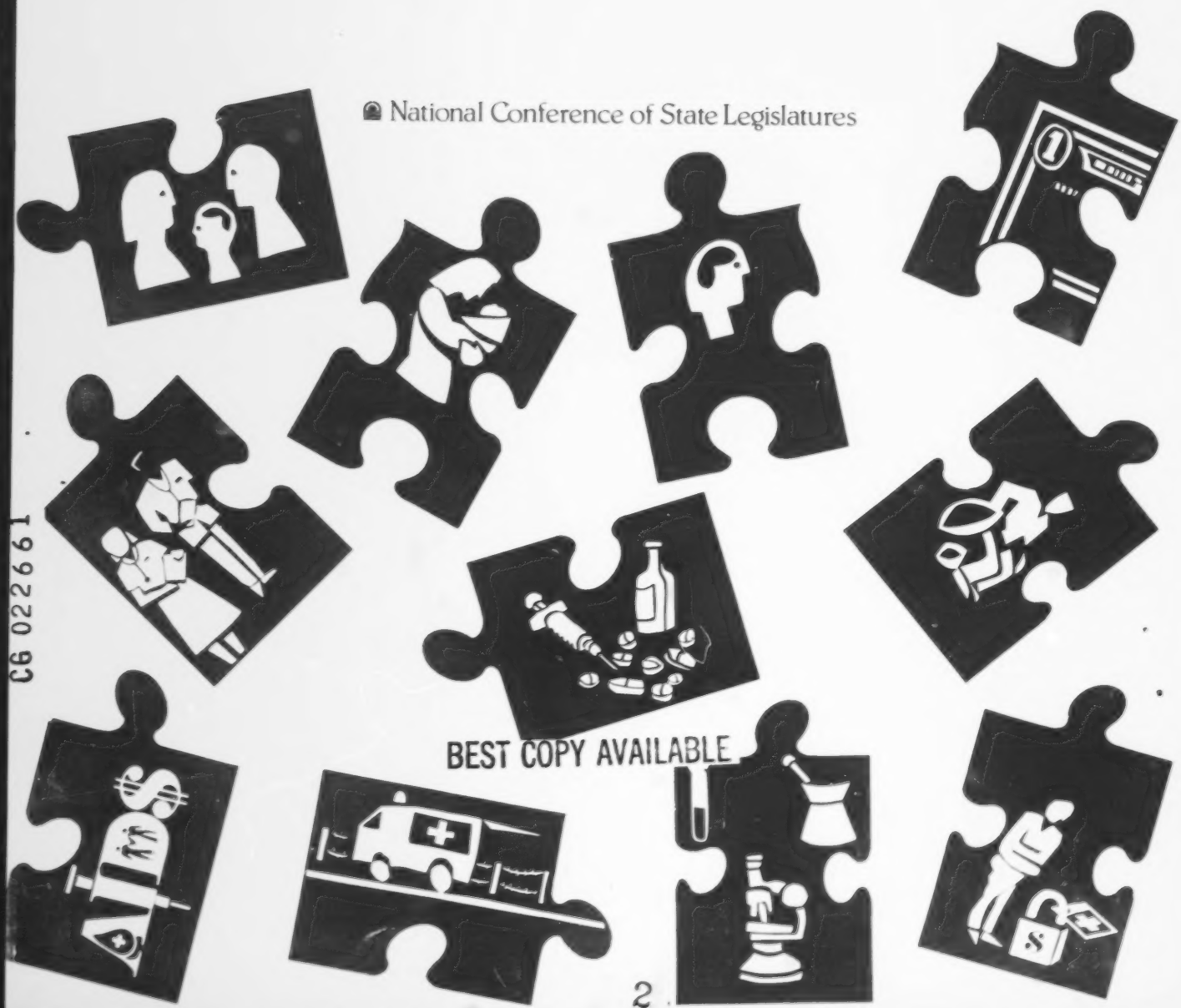
What Legislators Need to Know About Children's Mental Health

National Conference of State Legislatures



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- To ensure states a strong, cohesive voice in the federal system.

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What Legislators Need to Know About Children's Mental Health

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April 1990

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ISBN 1-55516-688-1

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Acknowledgments

This publication was made possible through a grant from the Robert Wood Johnson Foundation. We gratefully acknowledge the assistance provided by Michael Beachler, program officer at the foundation, and Robert F. Cole, deputy director of the foundation's Mental Health Services Program for Youth. The views expressed in this publication do not necessarily represent the opinions or policy of the Robert Wood Johnson Foundation.

The National Conference of State Legislatures gratefully acknowledges the contributions of the following persons who reviewed drafts of this publication: Ellen Kagen, CASSP Technical Assistance Center; Dr. Robert Friedman, Research and Training Center for Improvement of Services to Seriously Emotionally Disturbed Children at the Florida Mental Health Institute; Gary De Carolis, Vermont Department of Mental Health; Paul Vander Velde, Michigan Department of Mental Health and chair of the State Mental Health Representatives for Children and Youth Division at the National Association of State Mental Health Program Directors; Judith Katz-Leavy, CASSP, National Institute of Mental Health; Dr. Lenore Behar, North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; Barbara Huff, Federation of Families for Children's Mental Health; Dr. Jane Knitzer, Bank Street College; Dr. Felton Earls, Department of Behavioral Sciences at the Harvard School of Public Health; Gail Robinson, Associate Director, Mental Health Policy Resource Center; Roy Praschil, National Association of State Mental Health Program Directors; and State Senator Charles Bruner, Iowa.

NCSL also gratefully acknowledges the contributions that persons made in providing and reviewing information about their state efforts: Patrick Kanary, Ohio Bureau of Children's Services, Department of Mental Health; Gary Macbeth, Virginia Child and Adolescent Mental Health Services, Department of Mental Health, Mental Retardation, and Substance Abuse Services; John Van Den Berg, Alaska Youth and Adolescent Services, Division of Mental Health; Randy Feltman, California Department of Mental Health; Evelyn Shelley, Florida Alcohol, Drug Abuse, and Mental Health Children's Program, Department of Health and Rehabilitative Services; Paul Rode, Iowa Family-Centered Services, Department of Human Services; Jo Pine, Louisiana Division of Mental Health, Department of Health and Hospitals; Edward Hinckley, Maine Bureau of Children with Special Needs, Department of Mental Health; Ed Lake, Tennessee Department of Human Services; Karen Edwards, Tennessee Joint Select Committee on Children and Youth; and Rodney Copeland, Vermont Department of Mental Health.

The following NCSL staff made significant contributions to the publication: Martha King, program principal of the Health Services Program, who edited the drafts for content; Candace Romig, director of the Human Services Department, who reviewed the final draft; Sharon Schwoch, book editor, who provided copy editing and oversaw production of the publication; and Joyce Johnson, administrative assistant, who did word processing, layout, and table designs.

NCSL also thanks Bruce Holdeman for the cover design of the publication.

Introduction

Mental illness in childhood is costly. It costs the children and their families, who suffer emotionally and financially, and it costs society, which spends billions of dollars each year to provide care and treatment for children who are emotionally disturbed. Nationwide costs for children suffering from serious emotional disturbances exceed an estimated $20 billion annually.[1]

States have the primary responsibility for providing and funding child mental health services. State governments nationally spent between $750 million and $1.5 billion on children's mental health services in 1987.[2] This amount does not include figures for services provided by the health, juvenile justice, educational, and child welfare systems to children who are emotionally disturbed. State governments also oversee local governments and most private resources for mental health funding by regulating public and private providers and third-party insurers.

Despite these significant state contributions, two-thirds of the nation's three million children who are seriously disturbed are not receiving the services they need, while untold others receive inappropriate care.[3] The most disturbed youth may often be the least likely to get help. This is significant because between 50 and 80 percent of children and adolescents identified as seriously emotionally disturbed retain their disability into adult life.[4] Addressing a child's emotional disturbance early may forestall even costlier care as the child becomes an adult.

This booklet attempts to provide important background information on programming and financing systems for children with emotional disturbances to enable legislators to make educated decisions regarding child mental health in their states. The booklet is in a question-and-answer format and is organized as follows:

- The first two questions define *emotional disturbance* and present factors of concern to legislators, including increased services demand, inappropriate and inadequate services, and fragmented, uncoordinated delivery and funding mechanisms.

- Question Three outlines the services needed by children with emotional disturbances in the areas of mental health, social services, education, health care, vocational assistance, recreation, and family support. Question Four examines how services are delivered to children with emotional disturbances through the educational, juvenile justice, health, child welfare, and mental health systems.

- Question Five reviews the roles of federal, state, local, and private funding sources for serving children with emotional disturbances; and Question Six examines strategies to make the most efficient use of those resources at the federal, state, and local levels.

- Question Seven highlights innovative programs that a variety of states have implemented to improve the programming and financing of services for children with emotional disturbances.

Question One: What Is an Emotional Disturbance and Who Are the Children Affected?

At least 7.5 million children in the United States, or 12 percent of the nation's 63 million children under age 18, suffer from mental health problems severe enough to require professional mental health treatment. Between 3 and 8 percent of children experience severe emotional disturbances.[5] Broadly defined, *severe emotional disturbances* cause major impairments in functioning for an extended period of time. Children with emotional disturbances often experience periods of health interspersed with acute episodes of illness that leave their functioning impaired. Characteristics of emotional disturbances include the following:

- Difficulty with tasks of daily living;
- Recurrent problems in meeting basic survival needs;
- Extreme vulnerability to stress;
- Increased tendency toward alcohol or other drug abuse;
- Tendency toward episodes of "acting out" behavior that may interfere with the well-being of themselves or others or serious depression leading to suicidal acts;
- Lack of ability to develop personal social networks; and
- Inability to function in school.

Some children are at a higher risk of mental illness and disability than their peers because of environmental risk factors such as poverty, inadequate care, parental alcoholism, or divorce. Others are at high risk because of traumatic experiences such as physical or sexual abuse. Additionally, children with physical handicaps and chronic diseases and children of adults who have severe disorders are at higher risk of psychiatric dysfunction. These children also may benefit from mental health services.[6]

Childhood mental disorders vary in age of onset, types of symptoms, course, methods of treatment, and level of impairment.[7] Children may be afflicted by disorders that usually manifest first in childhood or by other disorders whose onset is not restricted to childhood. Excluding mental retardation and developmental disabilities, three types of mental disorders have their onset in childhood. The following disorders are listed by the area of functioning that is most impaired:[8]

- *Behavioral disorders.* These disorders are characterized by behavior that disturbs or harms others and that causes distress or disability. Behavioral disorders include attention deficit disorder, where a child is unable to maintain focused activity for more than a brief period; conduct disorder, where a child exhibits a pattern of behavior that violates social norms, often harming others; and substance abuse and dependence.

- *Emotional disorders.* These disorders have their most noticeable effect on a child's emotional state. Although the severity of a child's emotional problems varies widely, a diagnosable disorder must be accompanied by considerable impairment of a child's ability to function. These disorders include anxiety disorders, where excessive fearfulness and symptoms associated with fear interfere with a child's functioning, and childhood depression, which includes both depressed mood and impaired functioning.

- *Psychophysiological disorders.* These mental disorders involve a disturbance in some aspect of bodily functioning, usually a combination of mental and physical factors. These disorders, including involuntary movements of bodily parts and eating and sleeping disorders, place children at great risk since they pose threats to both physical and mental health.

Other mental disorders that affect children, but which more commonly begin in adulthood, include organic mental disorders, such as delirium or dementia; substance use disorders; schizophrenic disorders; affective disorders such as major depression; adjustment disorders; and a number of others.[9] Many children, particularly those with behavior disorders, also have as secondary diagnoses anxiety or depression. In addition, both depression and substance abuse increasingly are being diagnosed in children and adolescents.

Mental disorders in childhood often require care for an extended period of time and reduce the individual's ability to lead a normal, productive adult life.[10] Substantial evidence suggests that many childhood disorders extend into adulthood because of their chronic course, their adverse effects on the child's development, or a lack of timely and effective treatment interventions. Many severe childhood mental disorders can last a lifetime, and the cost of these disorders is high.[11] However, with proper mental health service interventions, many young people can and have gone on to live satisfying and productive lives.

Question Two: Why Should Legislators Be Concerned About Children Who Are Emotionally Disturbed?

Legislators should be concerned about children who are emotionally disturbed because state governments spend millions of dollars on services for these children and because lawmakers face increasing pressures to provide effective and cost-efficient services. In 1987, state mental health authorities spent between $750 million and $1.5 billion to provide services to this population, but many experts believe this estimate is low.[12] These children are involved in numerous, costly child-serving systems within their own states or sometimes in other states. In addition, millions of families are demanding stable, quality services for their children with emotional disturbances. In a time of strained state budgets, legislators are interested in getting the best, most efficient care and services for the money.

Several major factors contribute to the pressure on state legislators to find a more adequate, equitable, and explicit means of financing, programming, and delivering care to children suffering from emotional disturbances. These factors include increased services demand, as

exemplified by often inappropriate psychiatric hospitalization and rising youth suicide and alcohol and other drug abuse rates; inappropriate and inadequate services; and fragmented, uncoordinated delivery and funding mechanisms. These are issues that legislators can affect directly through their ability to influence federal funding, to review agency budgets and set appropriations levels, to set performance standards, to create or abolish programs, to establish law, and to advocate for children at the state and federal levels.

Increased Services Demand

A significant gap appears to exist between the number of children identified as needing mental health services and the number receiving them. An estimated 12 percent, or 7.5 million, of the 63 million children in the United States suffer from mental health problems severe enough to require mental health treatment.[13] The congressional Office of Technology Assessment estimates that between 70 and 80 percent of children in need may not be getting appropriate mental health services.[14] Between 50 and 80 percent of children and adolescents with severe mental disturbances do retain their disability into adult life—these inadequately treated children will generate an increased need for services in adulthood.[15]

Other indicators of increased mental health services demand among children and adolescents are a growing suicide incidence and increasing alcohol and other drug abuse. Suicide is the second leading cause of death among 15- to 24-year-olds. The suicide rate among this age group more than doubled from 5.2 per 100,000 in 1960 to 12 in 1985, and rates have increased again in recent years. Some of the most alarming data concern children between the ages of five and 14. The suicide rate for this group has increased from 0.4 per 100,000 in 1980 to 0.6 in 1985.[16]

Evidence exists that children with serious emotional disturbances especially may be vulnerable to substance abuse. Alcohol is America's number one drug problem among youth. In 1985, 4.6 million adolescents (ages 14 to 17) had some visible, easily identifiable problem related to alcohol: arrest, involvement in an accident, or impairment of health or job performance. Three out of every four teenagers drink alcohol regularly, and nearly 100,000 10- and 11-year-olds report getting drunk at least once a week. The extent of problematic drug use in adolescents is difficult to determine exactly. However, several national surveys indicate that psychoactive drug use by school-age children and young adults is widespread.[17] Children of substance abusers, in general, are more likely to be abandoned; physically, emotionally, or sexually abused; treated for psychiatric disorders; adjudicated for juvenile crimes; and committed for psychiatric treatment.[18]

Additionally, the numbers of children in poverty continue to increase, with accompanying increases in the stresses facing them. This group is particularly at risk for behavioral and emotional difficulties.[19] These untold numbers of at-risk children rarely receive the attention and secondary prevention services they need.

Inappropriate and Inadequate Services

Although there has been an effort to shift the emphasis in mental health services from residential to nonresidential care for children in all child-serving agencies over the past 15 years, the number of children with mental illness served by residential facilities has increased more that 50 percent since 1966. During that same period, residential care for other children and youth with other disabilities declined by more than 30 percent.[20]

A 1989 study conducted by the National Mental Health Association found that significant numbers of children are still being treated in state hospitals. The study found that 22,472 children nationally were placed in state hospitals in 1986. The average cost per episode was $38,218 based upon an average stay of 4.2 months.[21] In addition to the high usage of state hospitals, the hospitalization of adolescents in private psychiatric facilities increased 450 percent between 1980 and 1985, up from 10,764 youth to 48,375. These patterns of hospitalization have continued over the past 10 years and, in fact, may be escalating in some states.[22]

Additionally, the National Mental Health Association study found that many states appear to be high users of out-of-state placements for children who are emotionally disturbed. Children with emotional problems frequently are placed out of state by agencies other than the state mental health authority. The route by which a child is placed in treatment appears to have little relationship to the child's symptoms, and many such placements are made without adequate mental health assessment of treatment needs. Almost 90 percent of the states sampled in the study referred these children to private residential treatment facilities at an average cost of $52,300 per episode.[23] The lack of intensive family-based services and school-based services (including day treatment) and the absence of therapeutic foster care for children experiencing serious emotional disturbances have led to this overreliance on out-of-home placements.

The lack of community-based services to support children and their families has left the treatment of children experiencing serious emotional disturbances to inadequate, inappropriate services systems. Most state, local, and federal activity has not focused on prevention and early intervention activities or the development of community-based services for children and adolescents with emotional disturbances, despite the belief that these services are the most effective ways of dealing with the problems of these children. Although certain strategies are effective in preventing and minimizing mental disorders, prevention programs hardly exist.[24] Numerous studies, including one conducted by the Office of Technology Assessment in 1986, have found that services to children continue to be inadequate, especially community-based services and case management.[25] Children tend to be served by the state agency that has the funds available for the purchase of services, which either may not be the most appropriate service setting or may not supplement services with attention to mental health problems.

Fragmented, Uncoordinated Service Delivery and Funding Mechanisms

The existing service delivery system for children frequently lacks interagency coordination efforts, which are vital to meet adequately the unique and special needs of children. Families with a child who is emotionally disturbed often find themselves in a maze of services provided by a variety of agencies—a recent study revealed that one state had 22 separate state agencies and offices responsible for some segment of mental health services and no single agency to coordinate them.[26] Each agency has its own jurisdiction or turf and competes against other agencies for its share of available funding. A child may be known and served by several different agencies or programs, which may provide overlapping services. Fragmentation of resources often leads to irregular and compromised care.[27]

Inconsistent and inadequate financing for mental health care, especially for children, has contributed to major gaps and duplications in the services system. Many states cite that insufficient funding is the major obstacle to developing and coordinating needed services for youth who have severe emotional disturbances. For example, many of the federal initiatives for children with emotional disturbances, such as the federally funded Child and Adolescent

Service System Program (CASSP), have been good concepts, but the states and programs receiving assistance were forced to respond only to certain needs and populations due to inadequate funding. Most programs for children who have emotional disturbances are funded through a complicated mix of mechanisms and systems that varies from state to state. The federal government alone provides services through more than 30 programs that directly affect children. Additionally, the current reimbursement structure encourages the most expensive, most restrictive treatment settings for children. Federal and state government and private insurance almost always support hospitalization services and have started only recently to cover some community-based services.[28]

Question Three: What Services Do Children Who Are Emotionally Disturbed Need?

The choice of treatment and treatment setting for each child with an emotional disturbance is based on several factors, including the symptoms and the severity of the disorder, the child's developmental status, the availability of family support, social environmental conditions, the availability of financing for services, and the availability of services.[29]

All systems of care should include transitional and family support services. Children and adolescents with emotional disturbances continually go through a period of adjustment and transition as they change care settings and providers. A focus on these adjustments and transitions needs to be maintained throughout the service system to meet adequately the changing and future needs of a child. Transitional components include the following: specialized educational curriculum, community survival and living skills, vocational preparation and placement, and transitional planning and alternatives to residential services.[30]

All services should reinforce the vital role that families play in rehabilitating children with emotional disturbances. Family members perform many of the rehabilitative functions necessary for community living, but efforts are needed to utilize their assistance better. Families need crisis intervention services to handle the conflicts and crises that arise in caring for their children. Respite care provides members with needed breaks, while counselors, trained in caregiving and supervising, help with home care. Other forms of family education and support are helpful to family members. Families also may benefit from involvement in organizations or groups that provide education, support, and advocacy to parents or family members.

The ideal system of care for children with emotional disturbances includes the following: mental health, social, educational, health, vocational, recreational, and support services. The mental health dimension is divided into nonresidential and residential categories, which are detailed here.

Figure 1.

System of Care for Children Who Are Emotionally Disturbed

Source: CASSP Technical Assistance Center, Georgetown University Child Development Center.

Nonresidential Mental Health Services

The nonresidential services for children suffering from serious mental illness include prevention, early identification and intervention, assessment, respite and after-school care, outpatient treatment, home-based services, day treatment, and crisis and emergency services.[31]

- *Prevention.* Prevention consists of strategies to reduce or prevent the incidence of new problems through early identification, diagnosis, and treatment. For example, prenatal care is as important to the mental and emotional health of the child as it is to the child's physical health.[32] Other prevention activities include counseling to promote a child's sense of identity and self-esteem and the development of specific skills, particularly problem-solving skills; participation in self-help groups and support systems to help a child better handle crises and stresses; and modifications in systems to increase the likelihood that individuals will encounter favorable outcomes within the system, such as changes in school procedures to assist children who transfer schools and have transitional or adjustment problems.

- *Early identification and intervention.* Problems can be treated more effectively and economically if intervention begins early. Early recognition of health and emotional problems in children and the provision of appropriate services can reduce the duration and severity of the problems, as well as the overall prevalence of emotional disturbances in children. For example, parents, physicians, or staff of a day care, child welfare, or public assistance program may recognize early

symptoms of emotional disturbance and become key people in securing or providing the necessary intervention services.

- *Assessment.* Assessment services provide a professional determination of the nature of an individual's or family's problems, the factors contributing to them, and the assets and resources of the individual and family. For example, a child welfare agency may request an assessment to determine a child's suitability for adoption, a teacher may request one for a student, or a juvenile court may request one to determine the type of correctional placement for a child. Assessment is particularly important to a child due to the complexity of emotional problems and their failure to fit into established diagnostic categories.

- *Respite and after-school care.* Serious efforts to maintain children in their own community and provide sufficiently intensive care require services that provide relief and support to families and help parents (many of whom work) through supervised treatment and after-school programs. The need for respite care can be based on either the child's or parent's needs and may be used in a planned manner or at a time of crisis. These programs also help children learn appropriate social skills through involvement in community and recreational activities.

- *Outpatient treatment.* This type of treatment is the least intensive and most typically used intervention. The traditional approach is for the child or family to participate in individual, group, and family therapy. A variety of outpatient services, varying in intensity, frequency, and accessibility, is needed, including individual and family therapy and counseling, medication use, parent training, and social skill training.

- *Home-based services.* These are intensive services provided to children and families in their own homes. Some programs offer short-term, crises-oriented services, and others provide longer term intervention. These services do not eliminate the need for residential care in some cases but can provide an intensive, nonresidential alternative to hospital or other residential care for many. Counselors, sometimes working in teams, see each family immediately after the referral in the family's home. The intervention is multifaceted and includes skill training, helping the family obtain necessary resources, and counseling.

- *Day treatment.* Day treatment provides educational, counseling, and family interventions that involve a child for at least five hours a day. It is the most intensive of the nonresidential services that can continue over a long-term period. Children typically remain in day treatment for at least one school year, although shorter term programs exist. Day treatment services include special education, with an emphasis on individual instruction; individual, group, and family counseling; vocational training; crisis intervention; recreational therapy; and skill building, such as interpersonal and problem-solving skills.

- *Crisis and emergency services.* Many children enter the mental health system during times of crises, and unless these crises are dealt with effectively, children's problems worsen. Interventions need to be immediate. Treatment usually is brief and intensive. An ideal continuum of crisis and emergency services includes crisis prevention, identification, and management; crisis telephone hotlines; 24-hour emergency outpatient services; and intensive and immediate home-based interven-

tion. For example, mobile crisis teams respond to children and families in crisis at their own homes and link the child and family to longer term services to avoid unnecessary hospitalization.

Residential Mental Health Services

The residential services for children suffering from serious emotional disturbances include therapeutic foster care, therapeutic group home care, therapeutic camp services, independent living services, residential treatment, crisis residential services, and inpatient services.[33]

- *Therapeutic family home.* In this type of service, children are placed with foster parents ("treatment parents") who have been recruited and trained to work with children who are emotionally disturbed and who serve as the primary agents of treatment. A low staff-to-client ratio in these programs allows staff to work closely with the child, the biological parents, and the treatment parents. These programs are flexible, relatively easy and inexpensive to start, and the least expensive of residential treatment alternatives.

- *Therapeutic group home.* Care in a single home located in the community, which serves no more than nine or 10 children, involves an array of therapeutic interventions. Usually, couples are employed to live with the residents 24 hours a day, or staff are employed to rotate shifts. Some approaches emphasize group and individual counseling and therapy, while other interventions encourage positive behaviors.

- *Therapeutic camp services.* These programs allow children to live together in a wilderness setting, with a treatment emphasis on dealing with immediate situations of both a social and nonsocial nature. Group meetings, family therapy, and special education are emphasized in therapeutic camp services. These programs have the potential to help children acquire skills and attitudes for self-reliance and independence, thus developing self-esteem.

- *Independent living services.* Many states are developing a range of residential services to help children make the transition from home or residential programs to independent living. Vocational training and work experience are emphasized along with training in skills of independent living, such as managing financial, medical, housing, transportation, and recreation needs.

- *Residential treatment services.* Around-the-clock treatment and care are provided to children in these services. These programs provide individual, group, and family therapy; behavior modification; special education; and recreational therapy. For some children, residential treatment is used not only to meet their treatment needs, but also their need for a living situation since many families are unwilling or unable to care for these children themselves.

- *Crisis residential services.* In some cases, nonresidential intervention approaches cannot meet the needs of a child in acute crisis. Crisis services in a nonhospital, residential context can provide the level of support and intervention needed to resolve the crisis. These community-based settings provide short-term placement, provide acute and intensive treatment, and attempt to avert hospitalization.

- *Inpatient hospitalization.* Inpatient hospitalization is the most expensive, closely supervised, restrictive service and the one with the highest percentage of medical staff. It usually is reserved for extreme situations, such as short-term treatment and crisis stabilization for children in acute distress, comprehensive evaluations, and long-term treatment.

Other Support Services

In addition to mental health services, children with serious emotional disturbances may require the following service components: social, educational, health, court, vocational, recreational, and support services.[34]

- *Social services.* Social services support the functioning of family units in a variety of ways. These services include protective services, which are designed to prevent abuse, neglect, and exploitation of children by reaching out with social services to stabilize family life; financial assistance; home aid services, which include housekeeping and homemaking responsibilities; caretaker services to provide an adult in the home for brief periods of time when the parents are unavailable; and parent aid services to provide an abusive parent ongoing social support; day care; shelter services, which provide temporary placement for a child awaiting placement elsewhere; foster care, which is the placement of children who have been removed from their homes in foster family homes, group homes, group child care facilities, and residential treatment centers; and adoption, which is the permanent placement of a child who is unlikely to return to the biological parents.

- *Educational services.* Educational services provide children who are emotionally disturbed with programs and services to help them learn. These services include educational assessment and planning; resource rooms, which help maintain the child in a regular classroom through individualized assistance or consultation; special schools, which are nonresidential schools that provide a full-day educational program separate from the regular school; onsite mental health service teams and linked efforts to provide intensive school-based mental health services with intensive in-home services to families; residential schools, which are intensive residential treatment centers with school-focused programs; and alternative programs, which provide flexible services to children who may not be labeled as emotionally disturbed but who are in need of special help or additional structure. Newly emerging therapeutic preschools help children between three and six years of age manage behaviors and developmental delays.

- *Health services.* Health services detect and treat health impairments, many of which contribute to, exacerbate, or underlie emotional disturbances. These services include health education and prevention, screening and assessment, and primary acute and long-term care.

- *Court services.* For children with emotional disturbances who get in trouble with the law, court services can provide important supervision of daily activities. Judicial orders can be used to mandate treatment for the child and to ensure that the child attends treatment sessions.

- *Vocational services.* Vocational services are one of the most neglected services within the overall system of care. While employment is an essential key to successful integration into community life, only one-third of all youth with disabilities graduate to a job or some form of advanced education. These services include career education; vocational assessment; job survival skills training; work experiences with job coaches; job finding, placement, and retention services; and supported employment.

- *Recreational services.* Recreational services are critically important to the development of a child. For many children who are emotionally disturbed, isolation from peers is the norm. These children often miss important opportunities for growth and their emotional handicap may be compounded. These services include relationships between a child and a caring adult, such as the Big Brothers/Big Sisters Program, after-school programs, summer camps, and special recreational projects undertaken by service organizations in the community.

- *Support services.* Support services can make the difference between an effective and an ineffective system of care, but they do not fall into a specific category. These services include case management, which helps to plan and coordinate the services provided to the child by other agencies and advocate on the child's behalf; self-help and support groups, which provide emotional support and practical help for dealing with a problem that is common to all members; advocacy, which includes efforts to develop and secure needed resources and services for accomplishing particular goals; transportation; legal services to ensure that the child's rights are protected; volunteer programs, which serve as a resource in the development of service systems; and interagency collaboration, which helps ensure that services will be "wrapped around" the individual child and family.

Question Four: How Are Services Delivered to Children Who Are Emotionally Disturbed?

Children with emotional disturbances come into contact with many systems other than the mental health arena. The delivery system for children and youth also involves the criminal justice system, general health care services, education and special education, foster care programs, and social services. In addition, children are involved in vocational rehabilitation, substance abuse, and developmental disabilities programs.

The interrelationship between mental health and other service systems allows opportunities to identify children in difficulty, to provide interventions at the site where the mental health problems are identified, and to offer programs to prevent mental health problems. However, most states are in need of a gatekeeping system to ensure appropriate placements for children in the service system, especially out-of-home placements. A recent study by the National Mental Health Association indicates that slightly less than one-half of the states surveyed had an interdepartmental mechanism designed to review and approve out-of-home place-

ments. In addition, only about one-half had an interdepartmental entity to address policies and problems that cross more than one agency.[35]

In *Chronic Mental Illness in Children and Adolescents,* Ira Lourie and Mareasa Isaacs describe four primary systems, in addition to the health system, that provide services to children suffering from emotional disturbances: education, juvenile justice, child welfare, and mental health.[36]

Educational System

The federal Education for All Handicapped Children Act (P.L. 94-142) requires school systems to provide an appropriate educational setting in the least restrictive environment for every child described by a state as severely emotionally disturbed. A broad range of services, including mental health services, is permitted to ensure that children, including those with emotional handicaps, benefit from educational programs. Four million students received mental health services under P.L. 94-142 in 1984.[37] During the 1986-87 school year, approximately 8 percent of the special education students were behaviorally or emotionally disturbed, representing almost 400,000 children and youth.[38]

Amendments to the Education for All Handicapped Children Act (P.L. 99-457) extends the rights and protection of the act to all handicapped children beginning at age three, effective by 1990-91. These amendments also established a federal program for handicapped and at-risk children from birth to age three and their families.[39] States also are to provide services to infants and toddlers who are developmentally delayed or at high risk of developing such delays. From a mental health perspective, this includes infants and toddlers who fail to thrive.

Some schools have their own mental health professionals available to provide care; some rely on special education services, which were developed to serve the educational needs of children with learning disabilities and handicaps. Other school systems may refer children to various resources for treatment. Mental health interventions within schools generally are not widespread, nor are they usually coordinated with other care systems.[40]

A child enters the special education system when identified as *educationally handicapped*—usually defined as one who is two years behind academically. For certain diagnoses, such as deafness and autism, a child automatically qualifies for entrance into the system at the time of diagnosis, no matter how young the child. An evaluation is performed, and a plan is developed that prescribes the services recommended for the problem. School systems attempt to provide the child with the most appropriate, available resource at the least restrictive level of care possible. Placement in a residential school is the most restrictive step in this process.

Most often, services focus on the education of the child, not mental health treatment. There usually is little or no connection with available mental health resources in the community. A recent evaluation of programs within 13 states identified five major problems, including school curriculums that do not help children actively learn, solve problems, or think; behavior management geared to maintaining control rather than helping children gain control; inattention to the need for physical activities and socialization; an absence of support systems for teachers; and limited involvement of families in their children's program.[41]

Juvenile Justice System

Children who have an emotional disturbance also are served through the juvenile justice system, which offers guidance to youth who have broken the law and protects society from further offenses. Children enter the system when they are caught breaking the law. After initial police intervention, youth usually are referred to a juvenile intake unit where they are evaluated and referred for appropriate services. Although it is assumed that each child has a behavior problem and needs guidance, it is not necessarily assumed that these problems are related to mental illness.

If a child is found guilty, the court may develop an intervention plan for the child. A judge may place a child with serious emotional problems in a mental hospital or in long-term residential treatment, or the court may order community-based intervention at home or in a group home. If the child is found innocent, the system no longer has jurisdiction, and the emotional problems should be dealt with elsewhere, but usually are not.

The juvenile justice system often fails to meet the needs of children who are emotionally disturbed. Often a determination of what constitutes an emotional disturbance varies among service systems. As a result, many children do not receive appropriate services until they have severe problems. Even when mental health therapy is recommended, such services usually are not available through juvenile justice agencies and must be obtained privately.

Health System

Health services address a wide range of mental and behavioral problems of youth. Many children's mental health problems are seen by physicians in the course of delivering primary health care. Approximately 11 to 12 percent of pediatrician and family practitioner office visits are by children with psychological disorders.[42] The majority of children who are troubled visit their physicians because of physical complaints, and their mental health problems consequently are uncovered.[43]

Primary care providers are likely to be the first professionals consulted regarding developmental and psychological problems of young children. A recent study revealed that about 50 percent of pediatricians referred children who were troubled to a mental health professional, while the remainder treated the mental health problems themselves. However, systematic mental health interventions in physical care settings are rare. Only in settings such as health maintenance organizations might mental health referrals and interventions be more common.[44]

Child Welfare System

The child welfare system is another major service provider for children who are emotionally disturbed and has a similar range of services from which children can benefit. The welfare system, however, does not have an organized manner of directing children who are seriously disturbed to the services that they require. The children usually are moved among service settings based on their behavior and the availability of placement.

Children qualify for child welfare services if they are declared by the juvenile court to be neglected or abused. Although federal law requires child welfare officials to try to avoid out-of-home placement, services to families, especially intensive care, continue to be limited.

For children who are placed, initial placement generally is based upon the action of the parent and often is unrelated to any emotional disturbance that the child might have. During the initial placement in a shelter or group home, an emotional problem may require a child to be moved to a more restrictive setting. When available, outpatient intervention or therapy may be used. Children also may be placed in a foster or group home, or if required, in a local or state mental hospital. Children needing long-term, structured care are referred for residential treatment, sometimes in other states.

Several major barriers to receiving appropriate care exist in the child welfare system. First, the magnitude of the agency's tasks and the limitations of staff and training severely constrain adequate care. Often problems are recognized only when it is too late for a child to benefit from intensive home- and community-based services, and the child must advance to a more restrictive level of care. With each change in level of care, the child may change caseworkers. Another barrier is that the custody of the child often is taken from or relinquished by the parents to obtain available services within the system. In addition, placement in the welfare system for most children with emotional disturbances requires action by the juvenile court.

Mental Health System

Many mental health systems have only two levels of care: outpatient and hospitalization. When there are only two levels of care, the system's capacity to respond specifically to the wide range of children's needs is severely limited and they confront major problems in obtaining appropriate care. The care between levels often is not delivered in a systematic manner since community mental health agencies and hospitals often do not work in a coordinated way. When a child is ready for discharge from a psychiatric facility, the problems with the system really begin. Mental health systems provide some outpatient services through community mental health centers, but they often do not provide an intermediate level of care. Only if a child qualifies for one of the supporting agencies or has sufficient family resources can such care be obtained. Without qualifying, the child often cannot receive the most appropriate care.

The mental health system, unlike the other systems, has no mandate to serve all children who are emotionally disturbed, or even all those who are chronically mentally ill. Only when a child needs hospital-based care is the public system required to respond. This response often is inadequate or inappropriate. Many children who have emotional disturbances enter the public mental health system directly through a hospital, either at the state or community level. Entry may occur after parents bring the child to the hospital, following referral by another agency, or when the child is brought directly to the hospital by the police. Self-referral or referral from another agency is the entry point at a community mental health center. If families have the resources, some children go first to a private mental health provider. Once family resources have been exhausted and hospitalization in a private psychiatric facility no longer can be managed, often the children are transferred to the public system.

Question Five: What Federal, State, and Other Sources Fund Services for Children Who Are Emotionally Disturbed?

The responsibility for funding mental health services has shifted among federal, state, and local governments over the past 150 years. Financing mechanisms for children who have emotional disturbances often are complex, uncoordinated, focused on inpatient care, and limited in eligibility and benefits. Following are descriptions of local, state, federal, and private sources of funding. However, detailed information about the flow of funds for children typically is not available. These descriptions are based on data from adult systems.

Local Support

While local mental health boards or governmental units participate in mental health financing by controlling funds, delivering or contracting for services, and establishing priorities, their actual dollar contribution is small. Of the $11.1 billion spent by all levels of government to care for both children and adults with serious mental illness in 1983, only 2.7 percent were provided by local governments.[45]

Approximately 25 states use matching formulas to distribute mental health funds to counties. Matching funds act as an incentive for local governments to raise local dollars and to participate in planning a cost-effective system of mental health services. Local matches for specific purposes also can encourage or discourage use of services. For example, states can require a county match for state hospital care, but no match for local outpatient services. Often, local funding is directed at services that receive little state and federal funding, such as prevention and early intervention services, youth outreach, and public education.[46] Most states, however, cannot specify how much funding from either state or federal sources is targeted to children and adolescents, particularly through community mental health centers.

State Support

States are the centerpiece for providing and financing children's mental health services. This funding pattern is the result of having most of the services to such children provided by the educational, child welfare, juvenile justice, and mental health systems—these systems traditionally have been regarded as the responsibilities of states and localities.[47] Not only do they provide the vast majority of the funds to the state mental health agencies, states also oversee local governments and most private resources for mental health funding.

State lawmakers appropriate funds to the state mental health agency, which distributes the money to the state psychiatric hospitals and to local agencies. These programs, in turn, deliver inpatient and outpatient services to the community. These agencies may be public and private providers contracted by the state to provide specific services. State legislators further influence mental health financing by passing laws that regulate standards for public and private providers and third-party insurers.

States supplied more than 78 percent of the funds to support state mental health agencies in 1985.[48] The remainder was provided by federal sources. Nationwide, state mental health agencies directly controlled and administered more than $9.4 billion for mental health services in FY 1987 for adults and children who are emotionally disturbed. The majority of programs within states do not differentiate state expenditures by age groups. Consequently, it can only be estimated that states spend between 8 and 16 percent of their state mental health budgets on children, or between $750 million and $1.5 billion.[49]

Federal Support

The federal government finances treatment for children's mental health disorders primarily through the Alcohol, Drug Abuse, and Mental Health (ADM) block grant, Medicaid, and the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). This section examines these and several other federally sponsored programs for children who are emotionally disturbed. Table 1 specifies the federal contributions to programs providing mental health services to children.

- *ADM block grant.* The Alcohol, Drug Abuse, and Mental Health block grant provides funds to states for community mental health services. These block grants cannot be used for inpatient care. In 1984, Congress charged the states to set aside 10 percent of the ADM block grant monies for children and underserved persons. This entire 10 percent set aside was estimated to be less than $20 million nationwide in 1986, and only a portion of this was directed to new programs for children.[50] Although overall block grant expenditures have increased, the mental health portion has decreased from $249 million in FY 1987 to $237.6 million in FY 1990.[51]

- *Medicaid.* Medicaid is a federally matched, state-administered health insurance program for low-income families who meet certain categorical and financial criteria. These criteria vary from state to state since they are determined primarily by the states, but within general federal guidelines. The state plan determines the kinds of services covered by Medicaid. Reimbursed services also vary considerably from state to state. Medicaid serves approximately 11 million children and represents 55 percent of all public health funds spent on them. It has the potential to meet the needs of children who are possibly at the greatest risk of developing mental disorders—the poor, disabled, and uninsured. As Table 2 shows, the federal share of medical assistance in each state ranges from a low of 50 percent to a high of 80 percent.

  Several Medicaid options may assist children who are emotionally disturbed, including case management; personal care services; rehabilitation services; clinic services; and early and periodic screening, diagnosis, and treatment (EPSDT) services. A report on Medicaid coverage of mental health and substance abuse benefits for children and adolescents based on a 50-state survey conducted in 1989 will be available in the summer of 1990.[52]

  Recent federal legislation and regulatory interpretations have increased states' opportunities to receive federal matching funds for a wide variety of mental health and supportive services needed by children who are emotionally disturbed. Some of the more innovative strategies and new opportunities are detailed in Question Six of this report.

Table 1.

Federal Contributions to Programs Contributing to Mental Health Services for Children, 1985 (Dollars in Millions)

Federal Program[a]	Total Federal Contribution to Mental Health and Other Health Services	Mental Health Portion, Adults and Children	Children's Mental Health Portion	
			Amount	Percent of Total Mental Health Portion
Mental health services programs:				
Alcohol, Drug Abuse, and Mental Health (ADM) block grant (1981)	$ 490	$200[b]	NA[c]	NA
10 percent set aside for new mental health programs for children or other underserved populations (1985)	—	—	$10.6 to $20.0[d]	NA
Total	490	200	NA	NA
National Institute of Mental Health (NIMH) Office of State and Community Liaison	13	13	4.7	36%
Child and Adolescent Service System Program (CASSP) (1984)	—	—	4.7	36
Total	13	13	4.7	36
Third-party payment programs:				
Medicare (1966)[e]	69,707	NA	NA	NA
Medicaid (1966)	22,854[f]	NA	NA	NA
Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) (1966)	1,382.7	261.0	156.6	60
NIMH training, research, and prevention programs[g] (1947[h])				
Training	31.6	31.6	4.8	15
Research:				
Intramural	57.4	57.4	5.5	10
Extramural	98.2	98.2	21.7	22
Biometry and epidemiology	11.5	11.5	2.4	21
Prevention and special mental health	24.1	24.1	10.3	43
Communication and education	2.0	2.0	0.2	10
Total NIMH training, research, and prevention	224.8	224.8	44.9	20

[a] Figures in parentheses indicate fiscal year of program's initiation.
[b] Estimate; states have latitude to transfer limited amounts of funds across program lines.
[c] NA = Not available.
[d] A General Accounting Office survey of 13 states found that states planned to use from none to all of set-aside funds for children's services.
[e] The Medicare program for enhancing health care to the aged was enacted July 30, 1965, as Title XVIII of the Social Security Act, and expanded to cover the disabled beginning in July 1973, as legislated by the 1972 amendments to the Social Security Act (Public Law 92-603).
[f] In fiscal year 1985, states paid another $18,382 million in Medicaid.
[g] NIMH does not ordinarily aggregate expenditure data by age group; the figures presented here are rough estimates. In addition, NIMH was reorganized in 1985. Program names presented here have changed.
[h] NIMH was created under the Public Health Service Act of 1944 (42 U.S.C. 290 AA-3) and began functioning in late 1947.

Source: *Children's Mental Health: Problems and Service*, Office of Technology Assessment, December 1986.

Table 2.

Medicaid Matching Rates
Federal Medical Assistance Percentages

State	FY 1990	FY 1991
Alabama	73.21	72.73
Alaska	50.00	50.00
American Samoa	50.00*	50.00
Arizona	60.99	61.72
Arkansas	74.58	75.12
California	50.00	50.00
Colorado	52.11	53.59
Connecticut	50.00	50.00
Delaware	50.00	50.00
District of Columbia	50.00	50.00
Florida	54.70	54.46
Georgia	62.09	61.34
Guam	50.00*	50.00
Hawaii	54.50	54.14
Idaho	73.32	73.65
Illinois	50.00	50.00
Indiana	63.76	63.24
Iowa	62.52	63.41
Kansas	56.07	57.35
Kentucky	72.95	72.96
Louisiana	73.12	74.48
Maine	65.20	63.49
Maryland	50.00	50.00
Massachusetts	50.00	50.00
Michigan	54.54	54.17
Minnesota	52.74	53.43
Mississippi	80.18	79.93
Missouri	59.18	59.82
Montana	71.35	71.73
Nebraska	61.12	62.71
Nevada	50.00	50.00
New Hampshire	50.00	50.00
New Jersey	50.00	50.00
New Mexico	72.25	73.38
New York	50.00	50.00
North Carolina	67.46	66.60
North Dakota	67.52	70.00
North Mariana Islands	50.00*	50.00
Ohio	59.57	59.93
Oklahoma	68.29	69.65
Oregon	62.95	63.50
Pennsylvania	56.86	56.64
Puerto Rico	50.00*	50.00
Rhode Island	55.15	53.74
South Carolina	73.07	72.58
South Dakota	70.90	71.69
Tennessee	69.64	68.57
Texas	61.23	63.53
Utah	74.70	74.89
Vermont	62.77	61.97
Virginia	50.00	50.00
Virgin Islands	50.00*	50.00
Washington	53.88	54.21
West Virginia	76.61	77.00
Wisconsin	59.28	59.62
Wyoming	65.95	68.18

* For purposes of Section III of the Social Security Act, the percentage used under Titles I, X, XIV, and XVI and Part A of Title IV will be 75 per centum.

Source: U.S. Department of Health and Human Services, December 1989.

- *Medicare.* Medicare is a federally sponsored health insurance program for persons over age 65, persons who have received Social Security Disability Insurance payments for at least two years, and persons with end-stage renal disease. Only a small portion of Medicare funds is directly devoted to children who are disabled and to dependents of deceased, retired, or disabled Social Security beneficiaries.[53]

- *CHAMPUS.* The Civilian Health and Medical Program of the Uniformed Services is a health insurance program administered by the U.S. Department of Defense. CHAMPUS provides health benefits to 6.5 million military dependents and retirees who are unable to receive services through uniformed service medical treatment facilities. It is known as one of the most generous third-party payers for mental health care. To control the costs of mental health care, CHAMPUS has developed a new policy to limit its payments for hospital care and for residential treatment centers for children.[54]

- *Public Law 94-142 and Public Law 99-457.* The Education for All Handicapped Children Act (P.L. 94-142) mandates that most children who are physically and mentally handicapped be provided free, appropriate education and the "related services" necessary to obtain an education. The federal government provides a small amount of grant money to states to help them implement this law, but the requirements for compliance cost substantial amounts of state funds. There is continuing debate about whether mental health care is properly included under "related services" and who should shoulder the responsibility for payment of these services. The services to children who are emotionally disturbed available through P.L. 94-142 vary considerably among states.[55]

  Amendments of the Education for All Handicapped Children Act (P.L. 99-457) create a new mandate for state educational agencies to serve all three-, four-, and five-year-old handicapped children by 1990-91. In addition, P.L. 99-457 created the Handicapped Infants and Toddlers Program for handicapped and at-risk children from birth to age three and their families. Although the program is voluntary, financial assistance will be provided to states to establish statewide, comprehensive, coordinated programs of early intervention services; facilitate the coordination of early intervention resources from federal, state, local, and private sources; and enhance the states' capacities to provide quality early intervention services.[56]

- *Title IV-B and Title IV-E of the Social Security Act.* A significant number of children within the child welfare system have been abused and neglected and experience emotional problems. These children can benefit from services provided under the Title IV-B and IV-E programs. Title IV-B provides child welfare services, including family counseling, crisis intervention, and emergency caretaker services in the home. Funds are allocated to states according to a formula based on the number of children under age 21 and inversely related to per capita income. The federal government match for state IV-B expenditures is at a rate of 75 percent up to the appropriate amount allotted to a state based on the allocation formula.[57]

  Title IV-E authorizes open-ended federal reimbursement to states for foster care maintenance payments, adoption assistance for AFDC-eligible children, including special needs children, and administrative and training activities related to the program implementation. The program is administered by state agencies. Only children who would be approved for the Aid to Families with Dependent Children (AFDC) program are eligible for federally reimbursed foster care under IV-E. Federal matching payments to states range from 50 percent to 78 percent.[58]

- *Supplemental Security Income (SSI).* SSI provides monthly payments to children who are blind or disabled and whose family income and resources are below specified levels. Eligible children can receive $368 a month and also qualify for Medicaid in all but 13 states. States may provide supplemental programs to SSI recipients, but these programs vary greatly from state to state.[59] A recent Supreme Court ruling found that the SSI program had been improperly administered and that many eligible disabled children were denied benefits.[60] This ruling could have a substantial impact since as many as one million additional children might be eligible for the federal benefits.

- *Child and Adolescent Service System Program (CASSP).* CASSP has provided funds to states over the past six years to strengthen their capacity to respond to the needs of children and adolescents who are troubled. These CASSP funds are used to create or strengthen the focus on children and adolescents within mental health departments, to provide leadership in developing systems of services for the target population, to provide mechanisms for interagency coordination and family involvement, and to increase the capacity of the mental health system to serve those children in need. CASSP began with $1.5 million and its appropriation grew to $9.8 million in 1989. All states, except Michigan, Minnesota, and North Dakota, have received a CASSP grant to develop systems of care for children.[61]

- *Research and training.* The federal government is a major source of training and research support in the mental health area. About 15 percent of the National Institute of Mental Health's training funds are directed to training clinicians to treat children.[62] Federal funds support a technical assistance center for states with a CASSP grant and two national research and training centers in Florida and Oregon, funded jointly by the National Institute of Mental Health and the Department of Education.

- *Other.* Among the other federal programs that relate to children's mental health, directly or indirectly, are funding programs designed to enable individuals to meet basic health, nutrition, and cost-of-living needs. These areas probably have a major impact in preventing and alleviating mental health problems.[63]

  The federal government's support for children with serious emotional disturbances and their families parallels that of the states and local communities, with a maze of services and funding that often overlap. Children usually suffer because their services are presumed to be included in the omnibus programs, but often are not. Additionally, freezing budget levels has put many of the federal programs serving children in jeopardy.

Private Sector Support

Private insurance plans and private foundations are the primary sources of mental health funds within the private sector. Generally, private or public insurance programs provide limited coverage for mental health care—usually inpatient treatment is covered, but ancillary services such as day treatment, intensive home-based services, or crisis services are not.[64] However, several factors during the 1980s have increased the importance of private coverage for the care of youth who are emotionally disturbed. They include the passage of mandated benefits or mandated availability statutes in almost 30 states; some recent voluntary efforts by major private insurers to expand the range of mental health services covered; and the

recent dramatic increase in the utilization of privately operated inpatient hospital facilities by youth with private insurance coverage.[65]

The Massachusetts Health Security Act of 1988 has received widespread scrutiny and interest as one of the most comprehensive, aggressive attempts to provide health insurance to all state residents. The law is intended to extend health insurance coverage to state residents who do not have health insurance and who do not qualify for Medicare or Medicaid benefits. At least two health insurance plans that include mandated, minimum benefit packages for both mental health and alcohol and substance abuse services must be offered. Recent budgetary concerns within the state may jeopardize the implementation of this initiative.

Private foundations, 23,000 within the United States alone, contribute $700 million annually to health-related projects.[66] Although private foundation spending is dwarfed by federal and state mental health outlays, foundations are influential in mental health policy by strategic targeting of programs and issues not generally supported by government. The Robert Wood Johnson Foundation is providing more than $20 million to 12 states to improve the programming and delivery of children's mental health services. The initiative will encourage states to use a variety of strategies to finance a more comprehensive, balanced system of care for youth. Eleven states and the District of Columbia were awarded one-year development grants in July 1988. The 11 are California, Kentucky, Michigan, North Carolina, North Dakota, Ohio, Oregon, Pennsylvania, Vermont, Washington, and Wisconsin.

Question Six: What Innovative Strategies Are Available to Finance Child Mental Health Services?

Faced with increasing demand and decreasing funds for mental health services, states are looking for creative ways to stretch their dollars and use funds more efficiently. Following are some innovative state funding strategies.

Phasing down institutions. Several states, including Florida, New Jersey, Ohio, and Vermont, have undertaken projects to close state child and adolescent inpatient units and shift the savings to develop community-based services for this population. Colorado, Louisiana, Pennsylvania, and Texas also have initiated projects to reduce acute hospital capacity, but it is uncertain whether these initiatives will benefit child and adolescent services directly. Some states, such as Iowa, also have closed down juvenile institutions and diverted savings to create noninstitutional alternatives. A portion of these funds was used to provide intensive home-based services.[67]

Blending interagency budgets. Nebraska, Ohio, Tennessee, Virginia, and pilot projects in Iowa are combining funds from both federal and state sources to increase the availability and appropriateness of services. These states are blending resources dedicated to children within state mental health, education, juvenile justice, and child welfare agencies into a single budget. The pilot projects in Iowa will be evaluated to determine whether the flexible financing system results in more cost-effective delivery of services. Also, alternative reimburse-

ment systems will be developed to tie outcome measures to the finance system.[68] These initiatives are discussed in further detail in Question Seven.

Expanding Medicaid initiatives. Many children who are emotionally disturbed can receive Medicaid since virtually all children in foster care placements automatically are eligible. Some children qualify for Medicaid benefits through the federal Supplemental Security Income and the Aid to Families with Dependent Children programs. The Medicaid program provides an opportunity for states to receive federal funds because the federal government pays at least 50 percent of each state's Medicaid services. To the extent that the state Medicaid plan covers mental health services, the state benefits since providing mental health care to its citizens is primarily the state's fiscal responsibility. Examples of strategies that states can use in their Medicaid programs include:[69]

- *Expand home- and community-based services.* Services can be expanded under existing optional provisions where no waiver is required and involve rehabilitation, personal care, and clinic services, such as off-site home- or school-based clinic services. Sixteen states cover day treatment or partial hospitalization in inpatient facilities, and 26 states dispense these services in community mental health centers or clinics. Home-based services are covered in Kentucky, Maine, North Carolina, Ohio, and Washington. Maine, Michigan, Ohio, North Carolina, Washington, and Wisconsin allow intensive crisis counseling or emergency services. Mental health and medical care services are provided in residential treatment centers in Maine and New York, and Michigan includes assistance in daily activities and self-administered medication components under the personal care option. Recent federal Medicaid changes make it clear that services required under Individualized Education Plans pursuant to P.L. 94-142 also can be covered, including mental health services.

- *Seek waivers through the Medicaid Home- and Community-Based Services Program.* This waiver allows Medicaid dollars to be used, under some circumstances, to provide a broad range of home and community services to persons who otherwise would require care in an institutional setting. Despite the success of this program, Vermont is the only state that has an operational waiver for children who are emotionally disturbed.

- *Implement optional case management services.* Georgia, North Carolina, Pennsylvania, West Virginia, and Wisconsin have implemented a case management service that can assist children who are emotionally disturbed. In addition, three states have submitted plans to the Health Care Financing Administration, and at least six other states plan to pursue this available option.

- *Increase community mental health center reimbursement rates to leverage federal funds better.* States, particularly those with a high federal matching rate, can benefit by leveraging resources from the federal government in a better manner. Rather than relying on 100 percent state or local funds to subsidize operating deficits of community mental health centers, states can use the federal matching portion to expand services with no increase in state expenditures. If a state is now paying for 100 percent of a service, such as outpatient care, under this provision the federal government will pick up these costs up to the federal matching rate. For example, if Alabama paid for outpatient services with 100 percent state or local funds and its 1990 Medicaid matching rate is 73 percent, it is possible that the costs for these services will be only 27 percent rather than 100 percent.

- *Use mental health authority resources as state matching funds.* Although the fiscal resources used to expand Medicaid coverage historically come from the Medicaid agency's budget, the mental health authority's existing resources may be an appropriate and feasible source to make expansions. Maine increased reimbursement rates to community mental health centers in 1985 by 87 percent with both state and federal dollars. The state matching funds came from mental health authority resources. This strategy could be used for other types of service expansion options.

- *Cover inpatient services for individuals under age 21.* States have the option of providing Medicaid coverage for inpatient psychiatric hospital services for eligible individuals under age 21 at either freestanding facilities or state institutions. If states choose to use this option, they are able to leverage significant amounts of federal money, since they historically have been responsible for 100 percent of care costs for persons under age 21. The number of states that have opted for this coverage has increased from 22 in 1984 to 34 in 1987. The major deterrent of this financing strategy is that it is likely to stimulate increased demand for inpatient services. States using this option may want to consider developing strong utilization review and preadmission screening policies, as well as regulating the number of hospital beds that are created for children who are emotionally disturbed.

- *Adopt the special education system option to bill for health-related services.* In 1988, states were given the option to have Medicaid provide reimbursement for psychological and other health-related services, such as speech, occupational, and physical therapy provided to emotionally disturbed and other handicapped students by special education programs. Previously, the overall responsibility for providing these health-related services was up to each school district, thus offering an incentive to underidentify and underserve emotionally disturbed and other handicapped students. With this barrier removed, schools may play a larger role in helping meet the needs of emotionally disturbed and other handicapped children by using Medicaid funds as a new reimbursement source. While a number of states are considering this option, none has implemented it to date.

- *Use the early and periodic screening, diagnosis, and treatment services.* Through their EPSDT programs, states may offer additional services to Medicaid-eligible children, ages 0-18, without having to offer similar benefits to other Medicaid recipients. Congress strengthened this provision in 1989 by requiring that states provide coverage for treatment to correct mental or physical problems identified by EPSDT health screenings performed by physicians, even if these follow-up services are not covered under the state's Medicaid plan. This new provision enables states to cover a broad range of mental health services for children who are emotionally disturbed.

Developing fiscal incentives between state and local entities. Minnesota, Ohio, and Wisconsin have established single points of fiscal and program authority for both hospital and community funds used to provide services to adults and children with mental illness. These states generally allow county boards to develop and administer a range of community services. Ohio, whose system focuses on children, and Wisconsin may channel dollars saved through the reduction of state hospital usage to develop and fund community-based services.[70]

Some states have developed cost-sharing arrangements with local authorities for increases in state hospitalization usage beyond a targeted amount. The California Legislature passed a law that requires counties to pay for 10 percent of state hospital costs and 100 percent of the costs beyond a county's allocated inpatient days for children.

Expanding private insurance. States can utilize several strategies to expand the range of services available to privately insured children. Some states or communities have negotiated with private insurers to increase the range of services covered on a demonstration basis. Others have broadened coverage for community services. Prudential Insurance Company of America, the largest insurer in the country, has expanded its hospital coverage policies to include partial hospitalization or day treatment. Capitation-type arrangements have been developed between community providers and insurers that allow the delivery of a much broader range of services in anticipation that the utilization rate of inpatient resources will decrease.[71] Twenty states also mandate coverage of mental health services, and seven require private insurers to offer the option of mental health coverage.[72]

Developing a third-party billing plan. Recent federal legislation clarifies that Medicaid can be used to fund related services under a child's Individualized Education Program. Several states, including Connecticut and Utah, have developed a third-party billing plan to ensure that the education department recovers some of the cost of supplying "related health services" to handicapped children who have health insurance or who are Medicaid eligible. Insurers are billed for services from approved providers with parental permission. The plan is complex, but a 1987 General Accounting Office report indicated that the Connecticut plan has the potential of returning $5-$6 million in Medicaid payments alone. For 1988-89, $550,000 was returned to Connecticut in Medicaid reimbursement. Of that amount, $500,000 was from one of six districts in which the plan was piloted. However, there are concerns with the plan—if the insured party is denied coverage, coverage is reduced, or rates are increased because of third-party billing, the education department could be held liable.[73]

Establishing trust funds. The Self-Sufficiency Trust (SST) evolved from research by the National Foundation for the Handicapped. SST provides a mechanism for the families of children with handicaps to contribute money to their children without jeopardizing the recipient's eligibility for public programs. Income from the trust can be used to enhance, supplement, and enlarge services to all disabled residents receiving care from state-supported programs. Illinois was the first state to establish an SST in 1986, and Maine, Montana, and Oregon recently enacted SST legislation. Alaska, Florida, Hawaii, Massachusetts, Michigan, New York, and Virginia are considering proposals to create these trusts within their own states.[74]

Earmarking revenues. Earmarking, the practice of designating specific taxes and fees for particular programs, is receiving widespread national interest. Proponents claim that earmarking increases total state revenues, ensures a minimum level of funding for recipient programs, contributes to the stability of a state's financial system, and guarantees continuity for specific programs. Opponents of the practice caution that it may cause a reduction in the contribution that a program has been receiving from general fund monies—this may result in an actual decrease in funding from previous levels. In addition, critics warn that earmarking may result in unfair allocation of funds, and the traditional sources of earmarked funds produce relatively slow-growing revenues. Approximately one-half of the states designate state tax revenue for mental health and substance abuse services.[75] California, for example, allocates earnings from the sale of properties confiscated in substance abuse cases for a Primary Prevention Trust Fund. These monies are used to initiate collaboration or early intervention mental health and education programs in the school.

Providing family support dollars. Many families choose to provide care at home to a child who is emotionally disturbed. Cash assistance programs provide dollar resources directly to families, who in turn select and pay for needed services. Iowa has a small family support project for families with children who are developmentally or emotionally disabled. The project provides $260 per month to families for a variety of services such as respite care, food, clothing, and specialized treatment.[76]

Reusing surplus state hospital property. Although the number of public mental hospital patients has declined by almost 80 percent in the last 25 years, only 16 of the 274 state psychiatric hospitals have closed. This leaves many state psychiatric hospitals with empty buildings and surplus land that could be a source of funds or benefits for persons with mental illness. Potential exists to sell, rent, or lease empty buildings to new users or to lease land to private residential developers in exchange for a specified number of housing units or other benefits.

In recent years, there has been significant legislative activity relating to the reuse of state hospital property. Illinois established the Mental Health Trust Fund in July 1988, which earmarks revenues obtained from state hospital property leases for use by the Department of Mental Health. California authorized the lease of state hospital land, with income allocated to the Patient Benefits Fund to aid patients in five of the state hospitals. New York approved the lease of state hospital property to a housing facility and an alcoholism treatment program in 1988.[77]

Question Seven: What Are States Doing to Provide Care to Children Who Are Emotionally Disturbed?

Increased state, local, and private efforts during recent years clearly indicate growing attention to children who are emotionally disturbed and attempts to improve care systems. Some states are developing strategies and interventions to avoid the overuse of restrictive and institutional care for these children. Private foundations and other public interest groups are attempting to improve services through policy and programmatic decisions. Innovative programs are combining measures to produce successful, cost-effective treatment of children who have mental disabilities. Others are developing mechanisms to facilitate the coordination of care for children among various systems.

Idaho is developing innovative community-based and family-centered alternatives to hospitalization, including children's companion programs, classroom companion programs, and family treatment models for therapeutic foster care. Illinois is developing a system of care that will screen, assess, and provide support services to children who are emotionally disturbed and their families upon initial entry into the system, as well as identify service gaps and resource needs. Michigan established a single port of entry and exit for such children. In 1988, the Maryland and Minnesota legislatures authorized the development of a community-based continuum of care for children and adolescents with emotional disturbances. Pennsylvania now requires that all county applications for Child and Adolescent Service System Program funds be developed collaboratively by the county mental health, child welfare, and special education programs. South Carolina is maximizing Medicaid funds to reimburse family pres-

ervation, therapeutic foster care, day treatment, and residential services for children who are emotionally disturbed and their families.

The following examples illustrate a variety of approaches that states have implemented to improve the programming and financing of services for children with emotional disturbances. These programs were chosen to highlight a range of state activities in children's mental health and are not a comprehensive study of all state innovations.

Alaska

Profile. The Alaska Youth Initiative (AYI) allows children with serious handicaps to be served in their own homes or communities, sometimes in rural areas with as few as 200 inhabitants in a village. The initiative is an interdepartmental collaboration among the Department of Education, the Division of Mental Health and Developmental Disabilities, and the Division of Family and Youth Services.

Population. AYI started as a way to focus on children and youth who are the most seriously disturbed and who have multiple problems. Although the initial group of clients was identified as 34 youth who were sent to other states for treatment, eventually the program will serve all the state's children and adolescents whose needs cross agency boundaries. AYI also contributes support to an additional 50 youth with emotional disturbances who are in community programs.

Coordination and services. The focus of the program is on building services in the home, such as hiring staff to stay full time in the home or paying a relative to stay in the home during evenings. Each youth benefits from individualized family-based care and from local interdepartmental teams that determine the most appropriate services for his or her needs.

Two project coordinators report to an interdepartmental team, and three regional coordinators oversee local treatment and education teams that devise individualized services plans for each youth. AYI treatment teams have substantial flexibility in using funds to purchase a broad range and combination of treatment options. Each team develops a customized program to address the needs of the specific child and his or her family. As the needs of the child and family change, the program changes as well.

Results. In the first phase of focusing on children placed out of state, 28 of the 34 clients were returned to Alaska for community-based services. Currently, about 50 of the state's youth who are the most seriously disturbed are being served through AYI. Before AYI began, these youth were costing the state an average of $71,000 per person annually. The average cost per youth in the AYI program in 1989 was $40,562. Costs per client are higher in the first year of intensive services. By the third program year, each client's costs are projected to decrease an average of 36 percent. Of current clients, about 20 percent are in their family homes, 40 percent are in therapeutic foster care, 16 percent are in teaching family homes, 13 percent live in their own supervised apartments, and 11 percent are in residential care settings.

Funding. The Department of Education, the Division of Mental Health and Developmental Disabilities, and the Division of Family and Youth Services pooled a total of $1.8 million in 1987 to fund this initiative.

California

Profile. The California Legislature enacted the Children's Mental Health Services Act in 1987 to establish a comprehensive interagency service system for children on a voluntary basis throughout the state. This legislation was based on the effectiveness of the Ventura County Model, a demonstration project in Ventura County, California, that produced a comprehensive services system for children and increased interagency collaboration.

Population. This model serves a defined target population of clients who are severely mentally disordered and whose problems result in a severe disability leading to public sector fiscal liability or legal responsibility. Only after these clients are served are services provided to other, less needy clients. The Ventura County Model serves all children and adolescents within the county who are identified as seriously mentally disordered, totaling approximately 2,000 individuals.

Coordination and services. The Ventura County Model has five important characteristics:

- The target population is defined. Rather than providing treatment on a first-come, first-served basis, the county stipulates that clients must be children and youth with multiple problems who are separated or at imminent risk of separation from their families.
- Family unity and local treatment are the primary goals.
- The system provides alternatives to out-of-home placement and hospitalization.
- Mental health services are integrated with home, schools, juvenile justice, and social service environments. All new programs blend services, staff, and funding across agencies, including mental health, social services, special education, and juvenile justice.
- Evaluations help analyze public sector costs and benefits for the child, family, and community.

Based on the success of the Ventura County Model, participating counties under the 1987 enabling legislation are to phase in the following components over three years:

- Case management and other needed services, as defined by each county;
- Services for children who are the most difficult to place and services that permit a child to reside in the family setting, when in the interest of the child;
- Use of existing service capabilities within various agencies;
- Interagency collaboration by all publicly funded agencies and written interagency protocols and agreements; and
- Services provided in the least restrictive setting consistent with effective services and as close as possible to the child's residence, when out-of-home care is indicated.

Results. Results reported after two years were very positive for the Ventura County Model. Out-of-county, court-ordered placements of wards and dependents were reduced 47 percent. There was a 56 percent reduction in the rate of recidivism by juvenile offenders who are mentally disordered and who participated in the demonstration project. The hospitalization rate of minors fell 68 percent from the baseline fiscal year 1980-81 level. Out-of-county special education in residential, nonpublic schools is down 21 percent. Eighty-five percent of children at risk of imminent placement served by the intensive in-home crisis care programs remained at home more than six months. Special education pupils with mental disorders who were treated in the demonstration project's day treatment program have made significant gains in attendance and academic performance. In 1989, five years after the project began, the measures have remained at the same positive levels or improved further.

Funding. Cost avoidance achieved by the Ventura County Model is $1,173,812, or 77 percent of the annualized project expenses of $1,528,265.

Florida

Profile. Florida's mental health service system for children has had an interagency staffing mechanism for many years to review and make recommendations on residential treatment options. Now a similar mechanism focuses on nonresidential service planning. First introduced in FY 1987-88, Family Service Planning Teams (FSPTs) have been fully implemented in six service districts and are being developed in the remaining five districts for statewide implementation in the spring of 1990.

Population. The target population includes the following children with multiple problems who are already clients of either the Department of Health and Rehabilitative Services or the Department of Education, or both, and who have been identified as being emotionally disturbed or involved with substance abuse:

- Children in the child welfare system;
- Children in the delinquency system;
- Children of welfare recipients enrolled in a work incentive program; and
- Children identified by the school system as emotionally handicapped or severely emotionally disturbed.

Coordination and services. An FSPT is a multiagency, multipurpose team that assists parents and other caregivers in securing the least restrictive, most relevant and appropriate services necessary to keep their children living in the home and the community. Functions of the team include reviewing referrals for an array of services and developing, implementing, monitoring, and evaluating a family service plan. The team ensures services only to the intensity necessary to eliminate the specific problem areas identified in the family service planning process, with an emphasis upon maintaining the dignity of the child and family. The FSPT uses community-based, nonresidential resources to maintain the child in the least restrictive environment and to enhance the ability and likelihood of family participation.

The FSPT concept relies on the cooperative spirit generated by the interagency model of service delivery. Florida's SEDNET (Multiagency Service Network for Severely Emotionally

Disturbed Students) projects have been highly instrumental in implementing the FSPTs. Systematic assessment of the FSPTs will be provided through another multiagency initiative called the Quality Development Team. Initially created to review the effectiveness of the SEDNET projects, the Quality Development Team's procedures have been redefined to measure the health of each district's system of care and, over time, to measure the impact of the various system components, including the FSPTs.

Results. While no formal evaluation has been conducted yet, data show that waiting lists for residential placements dropped 29.7 percent, from 468 in FY 1986-87 to 329 in FY 1989-90, as a result of the implementation of Family Service Planning Teams. With the implementation of Florida's new CASSP grant, the FSPTs will be evaluated as part of an entire system of care evaluation.

Funding. The Florida Legislature appropriated $753,592 in FY 1989-90 to begin implementation of FSPTs in five of the 11 service districts. An amount of $3.6 million is being requested for FY 1990-91 for statewide implementation.

Iowa

Profile. Iowa legislators initiated a financing mechanism to test a system that ties funding to client need rather than program categories. Intent language in the 1987 agency appropriation authorizes three-year pilot projects for establishing a single child welfare budget to replace the current system of providing different services under multiple, separate funding categories. The two pilots in the Des Moines and Davenport areas began in July 1989.

Population. The two pilots must serve family and children in the child welfare, juvenile justice, and mental health systems as previously mandated, but more flexibility in determining the services mix is allowed.

Coordination and services. All or part of the amount that would be used for county residents for FY 1990 comprises the merged fund for the following services: foster care, family-centered services, day care, juvenile detention, state juvenile institutions, state hospital schools, mental health institutes, locally purchased services, and juvenile justice county-based services. With approval of the Department of Human Services, a project county also may elect to transfer funding provided to youth under Medicaid to the child welfare fund, including funding for psychiatric hospital services.

The merged fund requires the local county, court, and department officials to collaborate in the formulation of a written plan outlining the expanded or new services and governance of the fund. The pilot counties are expected to maintain budget neutrality. Savings realized through the utilization of less restrictive, less costly services will be redirected to develop alternative services that are more responsive to the needs of children.

Modifications to existing services and the development of new ones are planned for the pilot projects. New services will include day treatment, respite care, in-home care, parent assistance services, transportation, after-care services, family preservation services, preplacement counseling, needs-based foster care, independent living and flexible housing, and a family assistance fund. Modifications to existing services at one pilot project will include the following:

- Reducing the number of children placed in out-of-county institutional placements by enabling a local residential facility to open a secure, highly structured treatment program for delinquents during the project's first year;
- Making no new placements for certain children in the state residential facility and reducing placements in another facility;
- Revising the family foster care system to increase the number of homes available, the number of specialized homes, the quality of foster care, and compensation afforded to skilled foster parents;
- Exploring enhanced per diem rates and alternative payment rates to help providers develop needed programs;
- Implementing an early intervention pilot to serve families that are otherwise ineligible for existing family preservation services; and
- Allowing foster parents access to day care services for foster children in their care.

Results. The legislation requires comprehensive evaluation of the initiative to determine whether the flexible financing system results in more cost-effective delivery of services and development of alternative reimbursement systems, such as performance-based contracting, to tie outcome measures to the finance system.

Funding. The two pilot projects will be funded with approximately $25.4 million from state money previously spent for foster care, family-centered services, day care, juvenile detention, state juvenile institutions, state hospital schools, mental health institutes, locally purchased services, and juvenile justice county-based services.

Louisiana

Profile. The Louisiana Legislature created the Coordinating Council for Children and Families in the Office of the Governor in 1988. The legislation provides for establishing a structure for comprehensive planning, a coordinated service system, and collaborative budgeting for children with emotional disturbances and their families.

Population. The target population for this initiative is children with emotional disturbances and their families.

Coordination and services. The system of care is to include an entry point for service determination; integrated screening and assessment; case management; case review; collaborative evaluation; and a variety of services, including mental health, substance abuse, social, educational, vocational, and recreational. Services are to be child- and family-centered and must give priority to keeping children with their families. Services also are to be comprehensive and community-based, with decision-making responsibility and management at the regional and local levels.

A budget screening mechanism will help ensure that requests for funds used to serve youth who are emotionally disturbed are consistent with an approved statewide plan and a collaborative budget agreement. The newly created Coordinating Council for Children and Families is to approve both an annual and a five-year statewide plan for a system of care and to approve an

annual collaborative budget agreement, based on the statewide plan. Any budget request that pertains to children with emotional disturbances submitted to the Division of Administration by the Departments of Education, Health and Hospitals, Social Services, or Public Safety and Corrections, is to contain written assurances by the coordinating council that the request is consistent with the approved statewide plan and the collaborative budget agreement.

The legislature also created the Child and Adolescent Service System Program Statewide Committee. The CASSP Committee is to advise and report to the coordinating council on matters of policy and programs and to identify and recommend fiscal, policy, and program initiatives and revisions based on needs identified in the planning process. The act requires that a regional CASSP team be established in each of 10 geographic regions. Among other duties, the CASSP teams are to be the focal point of regional planning for children with emotional disturbances and their families residing in a team's region and to serve as the regional planning body for children with emotional disturbances.

Results. A supplemental CASSP grant formally will evaluate the initiative on client and project outcomes.

Funding. Federal CASSP funds will support the initiative through 1990. An interagency request for new funds recently was developed and sponsored by the governor's office for joint funding of coordinated departmental activities. This budget initiative will include funding for a 24-hour, interagency, single point of entry process for all agency clients.

Maine

Profile. The four major child-serving agencies, Mental Health and Mental Retardation, Corrections, Education, and Human Services, jointly coordinate planning and needs assessment efforts, license facilities, oversee funding, and provide oversight for programs that serve these children and adolescents. Maine uses three mechanisms to coordinate and provide services to children.

Population. Children and their families are served by any of the four participating departments.

Coordination and services. For 12 years, Maine has had an interagency planning office for children's services called the Interdepartmental Committee (IC) for Children and Families. This committee, recognized in statute in 1987, serves as the coordination point for state-level policy planning and funding for service needs of children and adolescents. Commissioners from the participating departments serve on the IC.

Maine also has created by statute the Interdepartmental Coordinating Committee for Preschool Handicapped Children (ICCPHC). The committee consists of representatives of Mental Health and Mental Retardation, Education, Human Services, private preschool agencies and organizations, and parents. The ICCPHC has gained recent responsibilities as the state's lead agency for preschool handicapped programs under federal Public Law 99-457.

In addition to participating in the IC and the ICCPHC to coordinate services with other agencies, the Department of Mental Health and Mental Retardation also coordinates services to children internally. The department created the Bureau of Children with Special Needs in 1985 to plan, deliver, and monitor services for children from birth to age five who are

developmentally disabled and delayed, and children and youth between ages six and 20 who have treatment needs that are related to mental illness, mental retardation, and developmental disabilities and who are not under the jurisdiction of any other agency. The bureau has a budget of almost $10 million and serves approximately 9,800 children and adolescents.

Results. As a result of this multiagency approach, Maine has improved children's mental health in the following ways:

- Increased and improved control and oversight of children's residential, psychiatric, and treatment services;
- Used each agency's limited funds for services more effectively;
- Increased development and use of less restrictive treatment settings and activities;
- Developed multiple agency funding mechanisms and procedures for community-based family service agencies as well as residential treatment centers; and
- Improved coordination of new services for children through the provision of technical assistance from the Interdepartmental Committee to potential providers.

The Bureau of Children with Special Needs reports that its community-based services are cost-effective. For example, home-based family services cost between $4,000 and $6,000 per client per year, compared with residential placements, which cost between $30,000 and $50,000. Even with its improved system, the bureau estimates that it is serving only about 25 percent of the children who need mental health services. Future plans include increasing that percentage.

Funding. Services and initiatives are financed by a combination of state and federal funds available to the various departments and are coordinated by the IC. These funds vary in proportions depending on the clients to be served and the identified lead agency for each child. In addition, special federal grant applications are prepared by individual departments and endorsed or supported by the others.

North Carolina

Profile. In response to a class action lawsuit settlement ("Willie M.") nine years ago, North Carolina has developed an integrated system of services in local communities for children and adolescents who are seriously emotionally, mentally, or neurologically handicapped and also are violent and assaultive. The system has been developed under the leadership of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (MH/DD/SA) in combination with all agencies serving children within the state. The local MH/DD/SA agencies are the lead agencies in this initiative. The state has a "no reject" policy, which prohibits these children from being denied access to appropriate services because of the nature of their problem.

Population. The target population for this initiative is children and adolescents who are seriously emotionally, mentally, or neurologically handicapped and also are violent and assaultive. In 1986, 1,900 minors were certified, with approximately 1,200 active cases at any given time.

Coordination and services. In addition to identifying and evaluating potential children, each local MH/DD/SA agency is expected to provide needed services, including the following: comprehensive case management services, outpatient diagnostic and treatment services and in-home services as needed; training in life skills, prevocational, or vocational preparation; residential treatment services and specialized foster care; and supervised apartment living or monitored independent living for older youths. These and additional services are provided by the area mental health programs separately or jointly with other public agencies, or they are purchased from private providers. The local school districts are expected to provide special education within the local education agency and special education in out-of-school placements for those children needing a more restrictive setting.

Results. Based upon the programs that have been in operation for nine years, North Carolina makes the following observations about its model:

- Children who are seriously behaviorally disturbed can be served in community-based programs. However, success is contingent upon having a wide continuum of services, a management system to keep the continuum flexible and responsive, and a case management system to develop service plans and oversee the implementation process.

- By using an individualized service plan approach, a child can be provided appropriate treatment within a system of generally used services, with additional services "wrapped around" the child. This enables a child to receive any needed services within any system regardless of the agency responsible for the child.

- Case management is considered the most essential unifying factor in service delivery, enabling coordinated planning and service delivery among all the agencies concerned with the child. A ratio of 12-15 clients per case manager is optimal.

Based on this model, the North Carolina General Assembly has adopted a child health plan to expand services over the next 10 years for all children who are seriously emotionally disturbed. Additional demonstration projects have adopted the Willie M. model to test further the effectiveness of community-based child mental health services. The Robert Wood Johnson Foundation Child and Youth Program is being operated in the 11 western counties—a very rural area. A Department of Defense Child/Adolescent Mental Health demonstration at Fort Bragg, which is operated by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, will provide a continuum of mental health services as an alternative to hospital-based care, using CHAMPUS funds. An independent, comprehensive evaluation of the impact of these services on the quality of care and the cost of care is being conducted by Vanderbilt University.

Funding. Funding for the 1,200 targeted Willie M. children is provided by a legislative appropriation of approximately $30 million per year. Additional state funding combined with third-party payments and other federal funds is scheduled to increase by $40 million over 10 years to meet the requirements of the Child Mental Health Plan. CHAMPUS funding for the Fort Bragg demonstration is approximately $5 million per year for the five-year project.

Ohio

Profile. Initiated by the governor in 1984, the Interdepartmental Cluster for Services to Youth was established in statute in 1987. The Interdepartmental Cluster is made up of six state agencies that provide services to children: the Departments of Education, Health, Human Services, Mental Health, Mental Retardation/Developmental Disabilities, and Youth Services. The Interdepartmental Cluster reviews issues and specific cases regarding multi-problem children and develops specific programs and services to meet their needs. Counties also are required to develop local area clusters.

Population. Most of the children referred to the clusters have a combination of problems, including mental or emotional problems; abuse and/or neglect; physical or mental handicaps, including mental retardation and developmental disabilities; learning disabilities or problems in school; and juvenile justice involvement, either as delinquent or status offenders. Many of the children have prior or multiple out-of-home placements. Of the more than 400 children referred to the Interdepartmental Cluster since May 1984, 97 percent have had serious behavior problems; 72 percent have been abused or neglected; 44 percent have been adjudicated delinquent; 24 percent have had physical or health-related problems; and 29 percent have had some degree of mental retardation. Children with two presenting problems or conditions accounted for 19 percent of the referrals received by the Interdepartmental Cluster, while 75 percent had three or more problems or conditions.

Coordination and services. Service delivery at the local, regional, and state levels is based on the individual child's needs, provided in a timely manner and in the child's home or community. Treatment plans are prepared jointly by the agencies responsible for serving the child. When a child must be removed from the home, placement is to be in the least restrictive, closest, and most family-like setting possible. Families are recognized as integral components of the treatment process.

County clusters accept and review individual cases of multineed children from local service providers; develop appropriate case plans for each child referred; coordinate service delivery; ensure that all appropriate local agencies are participating in programming and planning for the child; and coordinate activities and funding if a child must be placed in a specialized, out-of-home care program. Emphasis is placed on maintaining a child in his or her own home, whenever possible, by providing a range of family-based supportive services.

When a county cluster is unable to develop an appropriate treatment plan due to insufficient or nonexistent resources, programs, or funding, or is unable to develop or locate an appropriate treatment program for a multineed child, the case can be referred to the Interdepartmental Cluster for review and possible assistance. The cluster can intervene by trying to locate an appropriate treatment program, provide additional financial support for treatment costs through state Interdepartmental Cluster funds matched with local dollars, attempt to provide or develop a resource or program locally, help arrange for placement in a particular state-operated facility, or aid in developing other supportive services to maintain a child in his or her own home or in the community. The Interdepartmental Cluster also has the option of returning the case to the local cluster if it is found to be an inappropriate referral.

Although many of the cases referred to the Interdepartmental Cluster have warranted out-of-home placement, there have been a great many other referrals where children and youth have been placed in residential care because a comprehensive system of community-based programs and services was not available. To assist communities in developing community-

based services, the Interdepartmental Cluster also provides funds for local program development efforts. These funds are for the enhancement and creation of local systems of care, which consist of collaborative efforts and focus on intensive, nonresidential services that promote family preservation and reduce out-of-home placements.

Results. A grant of $3 million was allocated for several local systems of care. A component of the grant requires the local community to evaluate program effectiveness. The cluster also will provide an evaluation component to the grantees to assess the impact on the local system through indicators such as number of youth maintained in the home, number of youth returned from residential care, and reduced number of referrals to the cluster.

Informal indicators reflect that multiproblem children and their families are identified more readily by local providers, collaborative services are increasing within the state, and the child-serving systems are reporting greater levels of cooperation and collaboration.

Funding. Previously, each participating state department set aside dollars within its own budget for individual cases. Very limited funds were available for program development. For the 1990-91 biennium budget, each department identified an amount of funds for cluster purposes and then transferred those funds to a single line item within the Department of Human Services budget. In part, this created a blended and flexible pool of cluster funds. This pool has more than $7 million, with slightly more than one-half of that amount for individual cases. The rest supports local program development grants, training, and administrative activities.

Tennessee

Profile. Tennessee lawmakers created county-level ICAM (interdepartmental case assessment/management) teams to coordinate services for children on an individual basis. Legislation passed in 1986 focuses on bringing state agencies together to provide the most appropriate services and placements for children. Two regional AIMs (assessment, intake, and management) teams were established by the legislature in 1989 to develop a single interagency intake system for children who are potential wards of the state.

Population. The ICAM teams aid juvenile courts by making recommendations to judges about the best disposition of children alleged or found to be delinquent, unruly, dependent, or neglected. The two regional AIMS teams will coordinate services with county ICAM teams for approximately 600 children committed to state custody by juvenile courts.

Coordination and services. The ICAM teams, consisting of local representatives of the Departments of Youth Development (corrections), Education, Health and Environment, Human Services, and Mental Health/Mental Retardation, may be activated by the juvenile courts in all 95 counties of the state. Team members collaborate to make multidisciplinary assessments and recommendations for children who come before juvenile court judges. The team also works together to provide case management for multiproblem youth who need services from more than one department. The team's goal is to ensure that children in state care receive whatever services they need regardless of which department has custody. Legislation passed in 1987 requires agencies to share certain case-related information with ICAM teams. It also preserves confidentiality of data within the team and requires that parents be provided copies of ICAM reports.

The 1989 legislation created two pilot projects, the two regional AIMS teams, to develop a single interagency intake system for children who are placed in state custody by the juvenile court. The AIMS teams will test the feasibility and efficiency of interdepartmental assessment, placement, tracking, and case management of these children. The regional AIMS teams, implemented in late 1989, will coordinate services to children committed to state custody in two six-county AIMS pilot regions. In the AIMS pilot sites, the ICAM teams will provide noncustodial assessment and case management services. They will be used as a mechanism to prevent placement into state custody.

Results. About 900 cases were referred to the ICAM teams—635 for case assessment and 265 for case management. Over one-half of the cases had a verified handicapping condition and also behavior and truancy problems. Of those children that the courts recommended for assessment, parental custody was retained for 40 percent of the cases. No results have been obtained from the AIMS initiative due to the recent implementation date. The AIMS pilot projects do include a computerized information management system that will allow the state to track each child's progress through the service system. Additionally, an extensive evaluation will examine the possible organizational benefits of AIMS, as well as outcome data of each child, costs, and treatment effectiveness.

Funding. No special appropriation was made for the ICAM teams, and existing funds from agencies were used to support the statewide coordinator position. Approximately $700,000 was appropriated to support the staffing and services provided by the AIMS teams.

Vermont

Profile. Several years ago, Vermont implemented the State and Local Interagency Team system of care for children and adolescents who are experiencing severe emotional disturbances. Local Interagency Teams in the state's 12 catchment areas handle difficult cases that cannot be resolved through regular case management and networking. In 1988, the Vermont General Assembly formally created an organizational structure and new legal requirements for providing services to children and adolescents with severe emotional disturbances.

Population. The target population is children and adolescents with severe emotional disturbances and their families.

Coordination and services. Representatives from the community mental health centers, special education, child welfare services, and parents comprise the Local Interagency Teams. If an interagency team in any of the state's 12 catchment areas cannot provide needed services due to program gaps or restraints in funding or policies, the case is referred to the State Interagency Team. The state team attempts to meet the referred child's needs by accessing needed funds or by relaxing policy standards and regulations. It also attempts to resolve problems or issues on a systemwide basis if the need arises.

The Departments of Education, Mental Health, and Social and Rehabilitation Services are required to co-author and implement a system of care for children and adolescents with severe emotional disturbances and their families. The plan is updated and submitted to the legislature annually to help guide legislators in developing and making available appropriate services throughout the state. A governor-appointed advisory board of parents, advocates, and service providers, functioning since early 1989, advises the three commissioners about children and adolescents with severe emotional disturbances.

Results. Last year, 229 cases were reviewed by Local Interagency Teams, and 38 were referred to the State Interagency Team. Recommendations were given to help resolve each case, and trends were analyzed to help determine priorities for service system change both at the local and state levels. This, in turn, has produced a budget process that is coordinated across agencies. This interagency process for planning and budgeting has helped to use resources more effectively and efficiently. For example, a statewide network of intensive family-based programs has been established recently with funds from the legislature.

Funding. The Child and Adolescent Service System Program funds the administrative portion of this initiative, including the local mental health coordinators who sit on the Local Interagency Teams. Services are funded through regular departmental budgets, including a waiver through the Medicaid Home- and Community-Based Services Program.

Virginia

Profile. In the fall of 1987, the state department heads of Corrections, Education, Mental Health, Mental Retardation, and Substance Abuse Services, and Social Services developed the Interagency Consortium on Child Mental Health to promote innovative approaches to services for children and adolescents who are seriously emotionally disturbed and their families. The participating state departments and the Virginia Department of Health have come together to expand the interagency initiatives for 1990-92 with a joint department budget request totaling $6 million.

Population. The target population for this initiative is children and adolescents who are seriously emotionally disturbed and their families.

Coordination and services. Two means of reaching the goal of the consortium are the Interagency Funds Pool and the Local Interagency Service Projects (LISPs). The funds pool can be accessed by local community agencies on behalf of individual children whose service requirements cannot be met with current resources or legal mandates. Localities can access funds by developing a comprehensive treatment and education plan for a child, exploring the best ways to meet the goals and objectives in the plan, and applying for money to cover services that currently are unavailable in the community. The funds pool can be accessed only with the signatures of all four local agency directors.

Over the last fiscal year, 55 percent of the 98 applications received from 41 different Virginia localities were approved. Of the approved applications, residential care was approved for 48 percent, intensive in-home services for 28 percent, a combination of residential and intensive in-home services for 7 percent, and a variety of community services for 17 percent.

The Local Interagency Service Projects are competitively awarded grants in six localities to demonstrate more effective approaches to services delivery through cooperatively planned, managed, and operated services. Each locality was funded to develop up to three new services that tie in with existing services. The range of new services developed by the six localities includes case management, intensive in-home family preservation services, day treatment/education, and individual therapeutic homes.

Results. The first six months of operation for the six LISPs have demonstrated, through evaluation data, that incentives for local agencies to work together around the children and families who are most troubled can be successful in:

- Keeping children in their home communities;
- Providing more comprehensive services for children;
- Fostering an attitude of shared responsibility for children and services; and
- Promoting improved interagency working relationships.

Funding. The Interagency Funds Pool has received $500,000 from the Department of Social Services and $150,000 from the Department of Corrections. The LISPs are funded with $750,000 from the Department of Mental Health, Mental Retardation, and Substance Abuse Services and $62,500 from the Department of Social Services. These two departments have committed ongoing money to support these six projects.

Conclusion

States spent between $750 million and $1.5 billion in 1987 for child mental health services.[78] This amount does not include figures for services provided by the health, juvenile justice, educational, and child welfare systems to children who are emotionally disturbed. Nor does this figure include the financial toll and emotional pain that families endure or the later loss of productive adults in society.

State legislators should consider children's mental health a pay now or pay later problem. The problems of children with emotional disturbances, for the most part, get worse without treatment. Present data suggest that between 50 and 80 percent of children and adolescents identified as seriously emotionally disturbed retain their disability into adult life.[79] These unserved and underserved children grow up to be disabled adults, requiring extensive and expensive care.

Quality services are expensive, but lack of adequate care also is costly. Society pays for inadequate care through increased welfare rolls, increased crime, inappropriate health care, and lost productivity. During this era of tightening budgets, legislators must direct money where it will do the most good. Research and innovative demonstrations indicate that children with emotional disturbances can be treated both successfully and in a cost-effective manner by reducing reliance on residential and inpatient care. Given the appropriate support services, many of the children with emotional disturbances can further their education, get jobs, and lead productive lives in their communities.

State Information Sources

John VanDenBerg, Coordinator
Youth and Adolescent Services
Division of Mental Health and
Developmental Disabilities
P.O. Box H 04
Juneau, AK 99811-0620
907/465-2195

DeVon Hardy, Program Administrator *or*
Evelyn Shelley, Program Supervisor
HRS Alcohol, Drug Abuse, and Mental
Health Children's Program
1317 Winewood Boulevard
Building 6, Room 187B
Tallahassee, FL 32301
904/487-2415

Jo Pine, CASSP Coordinator
Department of Health and Hospitals
Division of Mental Health
P.O. Box 4049, Bin #12
Baton Rouge, LA 70821
504/342-0433

Lenore Behar, Special Assistant for
Children and Family Services
Division of Mental Health, Developmental
Disabilities, and Substance Abuse Services
325 North Salisbury Street
Raleigh, NC 27611
919/733-0598

Kim Skinner, AIMS-ICAM Director
Department of Human Services
Citizens Plaza Building, 14th Floor
400 Deaderick Street
Nashville, TN 37219
615/741-3024

Gary Macbeth, Director
Child and Adolescent Mental Health Services
Department of Mental Health, Mental
Retardation, and Substance Abuse Services
P.O. Box 1797
Richmond, VA 23214
804/786-2991

Randy Feltman, Director
Department of Mental Health
300 Hillmont Avenue
Ventura, CA 93003
805/652-6737

Paul Rode, Unit Manager
Family-Centered Services
Department of Human Services
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Des Moines, IA 50319-0114
515/281-3582

Edward C. Hinckley, Field Operations Manager
Bureau of Children with Special Needs
Department of Mental Health and Mental
Retardation
State House Station #40
Augusta, ME 04333
207/289-4250

Patrick Kanary, Chief
Bureau of Children's Services
Department of Mental Health
30 East Broad Street, Room 1135
Columbus, OH 43215
614/466-1984

Rodney Copeland, Director
Division of Mental Health
Department of Mental Health
103 South Main Street
Waterbury, VT 05676
802/241-2604

Child Mental Health Information Sources

American Bar Association
Commission on Mentally Disabled
1800 M Street, N.W., Suite 200
Washington, DC 20036
202/331-2240

Helps mentally disabled individuals obtain adequate treatment in humane environments and safeguards basic rights. Provides legal research services, produces publications on a variety of mental health issues, and publishes *Mental and Physical Disability Law Reporter* bimonthly.

Child and Adolescent Service System Program
National Institute of Mental Health
5600 Fishers Lane
Parklawn Building, Room 7 C 14
Rockville, MD 20857
301/443-1333

Provides federal leadership in child mental health and administers the CASSP grant programs to the states.

Child and Adolescent Services System Program
Technical Assistance Center
2233 Wisconsin Avenue, N.W., Suite 215
Washington, DC 20016
202/338-1831

Provides technical assistance and training regarding the development of family-centered, community-based systems of care for children who are emotionally disturbed and their families. Produces a number of publications about child mental health systems and services.

Children's Defense Fund
122 C Street, N.W.
Washington, DC 20001
202/628-8787

Conducts research and publishes information on issues affecting children; monitors governmental policies; provides technical assistance, information, and support; and litigates select issues.

Federation of Families for Children's Mental Health
1021 Prince Street
Alexandria, VA 22314-2971
703/684-7710

Serves as a national, parent-run organization that provides information and support on the needs of children and youth with emotional, behavioral, and mental disorders and their families.

The Information Exchange
on Young Adult Chronic Patients
P.O. Box 1945
New City, NY 10956
914/634-0050

Sponsors research on young adult chronic patients and the development of effective programs. Provides education and consultation about the population and effective ways of meeting its needs.

Intergovernmental Health Policy Project
George Washington University
2011 I Street, N.W., Suite 200
Washington, DC 20006
202/872-1445

Produces a monthly newsletter—*State Health Reports: Mental Health, Alcoholism and Drug Abuse*—concerning state legislation, reports and studies, and other pertinent mental health information.

Mental Health Law Project
2021 L Street, N.W., Suite 800
Washington, DC 20036
202/467-5730

Clarifies, establishes, and enforces the legal rights of mentally and developmentally disabled persons through test case litigation, technical assistance to direct service advocates, and policy advocacy at federal and state levels.

Mental Health Policy Resource Center
1730 Rhode Island Avenue, N.W., Suite 308
Washington, DC 20036
202/775-8826

Designs and produces materials to support decision making and to improve the information base for mental health policy process.

National Alliance for the Mentally Ill
2101 Wilson Boulevard, Suite 302
Arlington, VA 22201
703/524-7600

Alliance of self-help and advocacy groups concerned with improving services to those with severe and chronic mental illness. Produces a newsletter, *NAMI Advocate*, and other mental health publications.

National Association of State Alcohol
and Drug Abuse Directors
444 North Capitol Street, N.W., Suite 520
Washington, DC 20001
202/783-6868

Serves the directors of state and U.S. territorial authorities responsible for alcohol- and other drug-related programming as a national advocacy group that seeks to influence public policies affecting the field.

National Association of State Directors
of Special Education
2021 K Street, N.W., Suite 315
Washington, DC 20006
202/296-1800

Represents the state educational agencies and provides training, technical assistance, and information materials. Produces a variety of publications, including a quarterly newspaper, *Counterpoint*, and a monthly newsletter, *Liaison Bulletin*.

National Association of State
Mental Health Program Directors (NASMHPD)
State Mental Health Representatives for Children and Youth Division
1101 King Street, Suite 160
Alexandria, VA 22314
703/739-9333

Monitors federal and congressional activities and gathers and analyzes information about state government mental health programs. Also has divisions of state mental health attorneys, forensic directors, and children and youth representatives. Publishes a regular information newsletter, *NASMHPD Studies*, and various other informational publications.

National Center for State Courts
Institute on Mental Disability and the Law
300 Newport Avenue
Williamsburg, VA 23185
804/253-2000

Conducts applied research and program evaluations, provides consultation services, produces publications, and serves as a clearinghouse of information for state courts in the areas of mental disability and the law.

National Clearinghouse for Alcohol and Drug Information
Parklawn Building, Room 13A-44
5600 Fishers Lane
Rockville, MD 20857
301/443-0377

Federal government office that provides information on alcohol and drug abuse and drug dependence.

National Clearinghouse for Mental Health Information
National Institute of Mental Health
Parklawn Building, Room 11 A 33
5600 Fishers Lane
Rockville, MD 20857
301/443-4517

Provides information on all areas of mental health and mental illness.

National Conference of State Legislatures
Health Services Program
1050 17th Street, Suite 2100
Denver, CO 80265
303/623-7800

Provides specialized technical assistance to legislatures each year on state-specific mental health issues, including testimony, special workshops and seminars, and individualized assistance. Also produces a variety of mental health information materials and publications, including *State Legislative Reports*, books, a legislative resource directory, an annual mental health legislative summary, magazine articles, and monographs.

National Consortium for Child Mental Health Services
3615 Wisconsin Avenue, N.W.
Washington, DC 20016
202/966-7300

Provides a forum of information exchange on child mental health services and brings concerns regarding these services to appropriate local, state, and federal agencies.

National Council of Juvenile and Family Court Judges
P.O. Box 8978
University of Nevada
Reno, NV 89507
702/784-6012

Serves juvenile and family courts nationally through the provision of continuing education, technical assistance, research, and a variety of publications, including a monthly digest, *Juvenile and Family Law Digest*, and a quarterly journal, *Juvenile and Family Court Journal*.

National Mental Health Association
1021 Prince Street
Alexandria, VA 22314
703/684-7722

Serves as a consumer advocacy organization that is a central, national source for information about mental illness and mental health.

National Technical Assistance Center
for Mental Health Planning
1735 I Street, N.W., Suite 613
Washington, DC 20003
202/728-3939

Provides technical assistance to states and counties to improve and expand comprehensive community-based mental health systems. Produces a triannual newsletter, *Mental Health Planning News.*

Research and Training Center to Improve Services
for Seriously Emotionally Disturbed Children and Adolescents
Florida Mental Health Institute
13301 North 30th Street
Tampa, FL 33612
813/974-4500

Conducts a variety of research, training, consultation, and dissemination activities designed to increase the knowledge base in the children's mental health field. In addition to producing numerous publications, distributes a quarterly newsletter, *Update.*

Research and Training Center to Improve Services
for Seriously Emotionally Handicapped Children and Their Families
Portland State University
Regional Research Institute for Human Services
P.O. Box 751
Portland, OR 97207
503/725-4040

Conducts research on ways to improve services to help emotionally disturbed children; develops training materials and programs for professionals, parents, and employers; and serves as an information center. Also produces a quarterly newsletter, *Focal Point.*

The Robert Wood Johnson Foundation
Mental Health Services Program for Youth
Prudential Insurance Company of America
Group and Financial Service Office
56 North Livingston Avenue
Roseland, NJ 07068
201/716-8691

Provides up to $20.4 million in grants to maximize the functional abilities of young people with serious mental disorders. The program will foster coordination of existing mental health services agencies, expand funding strategies, promote interagency cooperation, and develop new mental health and related services for young people.

Notes

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Glossary

ADM Block Grant—The federal Alcohol, Drug Abuse, and Mental Health block grant that provides funds to states for community mental health services.

Capitation—A form of cost containment that pays for a service based on a set rate per person per time period.

Case Management—Services that link the individual with appropriate service programs, monitor progress, and provide advocacy services.

CASSP (Child and Adolescent Service System Program)—A federal program that has provided funds to states since 1982 to strengthen their capacity to respond to the needs of troubled children and adolescents.

Community Mental Health Centers—Private, nonprofit agencies that contract with county and state government to provide services to children and adolescents who are experiencing a severe emotional disturbance, adults with a mental illness, and children and adults who have a developmental delay.

Continuum of Care—A coordinated system to provide comprehensive children's mental health care at all levels.

Day Treatment—A day-long program that addresses both the educational needs and the mental health needs of the child through on-site counseling, recreation, and other interventions.

Emotional Disorders—Mental disorders characterized by the presence of an emotional problem and considerable impairment of a child's ability to function. They include anxiety and childhood depression.

Home- and Community-Based Services Program (or the "2176 waiver")—Allows Medicaid dollars to provide a broad range of home and community services to persons who otherwise would require care in an institutional setting.

Individualized Education Programs—Programs developed for every child identified as handicapped that determine the student's current educational performance and future goals and objectives.

Inpatient Treatment—Provision of mental health services to persons staying in a hospital overnight.

Least Restrictive Setting—A therapeutic or caregiving setting that limits a person's freedom of movement as little as possible.

Medicaid—A federal-state partnership program that provides health insurance to low-income families who meet certain categorical and financial criteria.

Medicaid Waiver—Provision of the Omnibus Budget Reconciliation Act of 1981 that allowed for a waiver of regulations prohibiting Medicaid reimbursements for certain community-based services. Waivered services must be necessary to prevent institutionalization.

Medicare—A federal program that covers the cost of hospitalization, medical care, and related services for the aged and disabled.

Outpatient Treatment—Provision of mental health services on an ambulatory basis to persons who do not require 24-hour or partial hospitalization.

Partial Hospitalization Program—A program designed to provide individualized therapy and rehabilitation for persons making a transition from inpatient care to a less intensive form of care or services, or as an alternative to inpatient care.

Private Psychiatric Hospital—Hospital operated privately by individuals, partnerships, corporations, or nonprofit organizations, primarily for the care of persons with serious mental disorders.

Public Law 94-142 (The Education for All Handicapped Children Act)—A federal law that mandates that all physically and mentally handicapped children be provided free, appropriate education and the "related services" necessary to obtain education.

State and County Mental Hospital—A psychiatric hospital that is under the auspices of a state or county government, or operated jointly by both a state and county government.

State Mental Health Agencies—Agencies under the auspices of state governments, staffed through the state, and offering mental health services to state residents in need of mental health care.

Substance Abuse Disorder—Mental disorders characterized by maladaptive behavioral changes resulting from regular use of substances that affect the central nervous system.

About the Author

Rebecca Tarkington Craig is the manager of the Health Services Program for the National Conference of State Legislatures (NCSL). Her major duties are to provide technical assistance to legislatures and to prepare reports on health issues facing state and local governments. She also is responsible for raising over one-half million dollars annually and managing seven health projects. Ms. Craig has written several books and numerous articles and issue briefs about mental health, substance abuse, and developmental disabilities.

Prior to joining NCSL in 1985, Ms. Craig managed a statewide family support and advocacy organization and prepared persons who are physically and emotionally handicapped for employment. She received a master of social work from the University of Denver and a bachelor of science from the University of Alabama.

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